



Report of the Inspector of Mental Hospitals

for the year ending
31st December, 2002

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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 2002 on psychiatric hospitals and services and the care of patients therein. This is my fifteenth 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 Joan Moore of the Health Research Board, Ms Sinead Curristan and Ms. Iverna Higgins 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 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. Much fuller and 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

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.

The Psychiatric Services in 2002 — An Overview

THE PROCESS OF INSPECTION

The Mental Treatment Act, 1945 requires the inspection of every public psychiatric hospital and unit at least once a year, and of every private hospital and the Central Mental Hospital twice a year. These inspections were carried out on both announced and unannounced visits. In recent years, the number of unannounced visits has increased. The general format of an announced visit is that the Inspectorate, before beginning the inspection, meets with senior members of the service being inspected, bringing with it the statistical returns made by that service to the Department of Health and Children at the end of the preceding year and a copy of the health board's service plan in respect of the service. The Inspectorate conducts a general review of the service with senior service personnel at this pre-inspection meeting, with particular reference to any new or proposed initiatives being undertaken, and requests the views of the service providers on the content of the preceding year's Report and its recommendations. At the conclusion of the visit of inspection, the Inspectorate gives the senior service providers or management team the opportunity to meet again with it, and it outlines the highlights of the inspection visit. When a visit is unannounced, a formal meeting before inspection may not be possible because the members of the management team may not be available, being taken up with routine duties. Nevertheless, such meetings usually do take place, either during lunch or at the conclusion of the visit. More recently, the Inspectorate has been concerned to meet psychologists, social workers and occupational therapists, in addition to doctors, nurses and administrators, to hear their views. In some cases, this has not been possible because there have not been any of them in the service.

The process of inspection is primarily concerned with quality issues as set out in *Guidelines on Good Practice and Quality Assurance in Mental Health Services* (Department of Health and Children, 1998). As the consumer voice is of primary importance to the Inspectorate, structured interviews are carried out with a randomly selected number of in-patients to obtain their views on the service provided for them. At the conclusion of each service visit, the draft report is compiled and distributed to the service providers for comment on matters of fact. It must be appreciated that information provided to the Inspectorate during the course of a visit comes from a number of disparate individuals and may not always be accurate. For this reason, health boards and other service providers are given the opportunity to correct any factual errors that may have crept into a report at the draft stage. The draft reports are then returned to the Inspectorate and corrections are incorporated into the final report. Any comments made by the health boards on matters of quality and standards are considered on their merits. Changes in the Inspector's appraisal of these matters are made only if the comments received are shown to be credible and warranted. In these matters, the Inspectorate is committed to objectivity and

impartiality so that the reports constitute an adequate, fair-minded account of the services provided and of their performance.

Inspection visits to the smaller services usually last one-day; those to the larger services may take longer. The issue as to whether visits of relatively short duration are sufficient to gain insightful impressions of the way in which a service operates might legitimately be raised. It might even be suggested that the Inspectorate should spend a 'working week' in each service, accompanying staff in the day-to-day performance of their duties for the purpose of observation, and that inspections should be made, unannounced, at 'out of hours' times, such as at night or on weekends, to get a flavour of what goes on outside the ordinary working day. Such intensity of input needs the justification of an exponential increase in knowledge and insight as to the day-to-day operation of the services to warrant the increased Inspectorial time and effort required. Such a 'paternalistic' presence might be interpreted as meddling and might reduce goodwill in individual services. Furthermore, the Inspectorate is supplied with a great deal of objective information, and acquires more during the course of the inspection, which tells its own tale. Because the Inspectorate visits each service annually, and often more frequently, it is therefore very familiar with the main features and operating characteristics of the services at all levels; the additional time required by an intensive and more time-consuming input, with little likelihood of gaining additional insights, hardly seems warranted.

The Inspector's reports on services attempt to maintain objectivity and fairness throughout and take account of the value of encouragement and support, rather than unconstructive criticism. Nevertheless, where conditions or procedures exist which the Inspectorate considers require change or improvement, there has never been any flinching from honest and helpful evaluation. Ultimately, the Inspectorate serves the consumer interest and even though, in some quarters, transparency and accountability are relatively new and sometimes threatening aspects of daily work for the mental health services, which for so long were closed and guarded, a cultural thrust forward is necessary to achieve the openness and self-scrutiny essential to evaluating the quality, efficiency and efficacy of modern health care systems. This is all the more so in the field of mental illness where so much in diagnostics and treatment is yet uncertain and open to many different views, making its intelligibility and understanding confusing and difficult for the consumer. Linked to the consumers' impressions of services delivered is the consideration of whether there is consumer representation on planning groups in local services. Increasingly, services are being asked to take into account, heed, and react to the consumer voice. This is equally important at the individual patient level in setting up a partnership approach to designing a treatment plan agreed between patient and doctor and involving relatives when that is appropriate.

The designation, Inspector of Mental Hospitals, derives from the Mental Treatment Act, 1945, at a time when the entire mental health service provision consisted almost exclusively of mental hospitals. The situation has greatly changed and, increasingly, more mental health care is delivered in non-hospital settings than is provided in hospitals. Accordingly, the role of Inspector of Mental Hospitals has had to acknowledge this reality. Indeed, the new legislation, the Mental Health Act, 2001, takes account of this by the creation of an

Inspectorate of Mental Health Services, rather than of mental hospitals. Over many years, the present Inspectorate has included community-based services within its brief, in addition to services of the traditional, institutional type. There are other areas of mental health care which, although not legislatively or logistically coming within the Inspectorial remit, are nevertheless of considerable concern. These include mental health promotion on a community basis, access to primary care for persons with mental health problems, and the organisation and quality of primary health care so that it can effectively recognise, diagnose, treat and refer persons with such problems. The Inspectorate is, likewise, concerned about support for carers of persons suffering from major psychiatric disorder, on whom considerable burdens devolve, no matter how adequate the help available from the statutory services may be. The Inspectorate is also deeply concerned about safety issues, and advocates the enhancement of safety provisions and measures available to mental health service staff through the training programmes put in place for them, both on induction and subsequently, and through the existence of risk assessment procedures.

The Inspectorate studies service plans, both those for the coming year and those of longer remit, to gain an insight into the direction in which managers see their services evolving. In the consideration of structural and physical provision, the Inspectorate is concerned in each service with assessing the extent and quality of service provision in six main areas. These are:

- Community mental health care and day hospital activity;
- Day centre activity;
- Rehabilitation, residential community placement and recovery services;
- Acute in-patient services;
- Primary care liaison activity;
- Home care programmes;
- Specialist psychiatric services.

In relation to procedures and practices, the Inspectorate gives attention, in each service, to the following, non-exhaustive, list of issues:

- Case record structure, quality of entries and documentation, medical, nursing and other;
- Prescribing practices and documentation;
- Consumer involvement in service planning;
- Care planning and patients' involvement in planning individual care programmes;
- Risk assessment and management;
- Patient privacy and dignity;
- Complaints procedures, complaints officers and complaint management and recording;

- Seclusion, its practice and documentation;
- Protocols on the locking of in-patient accommodation;
- Accidents and incidents, their recording and prevention;
- Patient money management systems;
- Policy on search of patients and their property;
- Patients absent without leave;
- Follow-up and care programme approach for patients on discharge from in-patient care;
- Policies and procedures generally and clinical and administrative guidelines.

The Inspectorate has an advisory role to the Minister and the Department of Health and Children on mental health policy, the implementation of the Mental Health Act, 2001 and the establishment of the Mental Health Commission. In addition, the Inspectorate provided professional advice to the Minister and Department as required. Finally, the Inspectorate was available to service providers and planners and clinical and administrative staff to advise on matters of a clinical/administrative nature and issues of legislation. The Inspectorate also served on a number of intra- and inter-departmental groups during the year.

In summary, the Inspectorate, in focussing on service delivery at the interface between patients and relatives and the service available to them, by collecting information, observing practices and using collective experience and judgement, encourages compliance with the Guidelines on Good Practice and with the provisions of the Mental Treatment Act, 1945 and the Statutory Regulations. In reporting annually to the Minister the Inspectorate guarantees some measure of public accountability for standards in addition to promoting more responsive and innovative service.

THE REPORT

This report consists of two main sections. The first presents material on general issues, the second, a resume of matters in each hospital within each health board and, separately, on private hospitals. The individual 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 2002

According to figures supplied to the Department of Health and Children by service providers, there were 3,966 patients resident (including those on parole) in psychiatric hospitals (public and private) and acute psychiatric units on 31 December 2002. During that year there had been 24,286 admissions to these in-patient facilities, of which 2,723 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 also in *Irish Psychiatric Hospitals and Units Census 2002* and *Activities of Irish Psychiatric Services 2001*, published by the Health Research Board.

The majority — fifty-five per cent — of patients in hospital at the end of 2002 were long-stay being continuously hospitalised for over one year, over one third of them for over five years and the majority of the long-stay were over sixty-five. On the assumption that few, if any of these long-stay patients will ever be discharged, through the application of life table estimates the continuing decline of the resident long-stay population can be projected. The origin of our calculations is the detailed census of patients resident in psychiatric hospitals and units carried out by the Health Research Board on the 31 March 2001. Although a year and a half older than the present report, the HRB report is more detailed and hence a better basis for these calculations. It should also be borne in mind that psychiatric in-patients have a higher mortality than the general population, therefore, life table calculations coming from general population estimates will over-estimate life expectation.

The application of life tables to the over sixty-five-age-group, most of whom are long-stay, and assuming that there will be no discharges, shows that two-thirds will have deceased by 2011, with further mortality over the following years. Health Research Board data, (and these matters are being pursued further by that body), indicate that the under sixty-five-age-group new long-stay (over one, and under five years continuous hospitalisation) and the old long-stay (in hospital for more than five years continuously) is falling, through discharge and community placement, at a far greater rate than, at the other end, current patients are becoming new long-stay. The implications for the reduction of hospital accommodation and the requirement for correspondingly increased community residential provision are obvious.

SOME ACHIEVEMENTS DURING THE YEAR

The Inspectorate has thought it appropriate to highlight some of the major advances of the year in provision of psychiatric care delivery during the year. These were, as the Inspectorate perceived them:

- There has been considerable reinforcement of various sub-specialities during the year indicating the commitment of the Department of Health and Children to extending and strengthening the range of services available. Thus, the year has seen the appointment of additional consultant psychiatrists in Later Life Psychiatry, bringing the total number of such teams in the country to twenty-one.
- Similarly, there has been the creation of a further consultant post in Child and Adolescent Psychiatry, increasing the total in this sub-specialty to forty-eight. In the field of Rehabilitation Psychiatry, further posts were created during the year, thus establishing five posts in total. Liaison/consultation psychiatry in general hospitals was also a beneficiary, with the total now standing at seven.
- The existing two posts in Forensic Psychiatry have been increased to five based in the Eastern region and attempts are being made to establish special interest posts in the Mid-Western and Southern Health Board areas.

- There has also been an augmentation of consultant posts in the field of Intellectual Disability to a total of thirty.

These newly-created posts recognise at official level the increasing complexity of psychiatric disorder and the growth of our understanding of some of the antecedents and consequences of major mental disorder. Nonetheless, it is important that there be further expansion of these sub-specialties on a regulated and supported basis. The necessary human and physical sub-structures must be put in place to ensure that each team in the sub-specialties is truly multi-disciplinary and is not isolated from mainstream psychiatric services while, at the same time working in close harmony with the generic services of its sub-specialty.

The transfer of intellectually disabled patients from inappropriate placement in psychiatric hospitals continues and the successful move to much improved conditions of such persons from St Bridget's, Ballinasloe, St Joseph's, Limerick, St Finian's, Killarney and Our Lady's Ennis (on its closure) during 2001 were added to, during 2002, by those moving from St Mary's Castlebar, St Bridget's Ardee and St Canice's Kilkenny.

- There have been, during the year, further increases in the acquisition of and provision of community facilities such as day services and community residences. However, the Inspectorate has some reservations about the design features of some of the buildings proposed for use as day hospitals and would like to see the programme of community residence provision accelerated and extended to eliminate the occupation of acute beds by patients whose illness and needs are no longer acute. At the same time, the Inspectorate is very aware of the difficulty facing service providers in procuring suitable property at reasonable cost for this purpose. However, some services have shown admirable initiative in working with voluntary agencies in acquiring Department of the Environment funding for such facilities. This is particularly important if the closure of mental hospitals is to proceed as planned and if new long-stay patients are not to build up in acute beds.

DISAPPOINTMENTS DURING 2002

The failure of three psychiatric general hospital units to open as planned was particularly disappointing. First, was the unit at St Luke's Hospital, Kilkenny. During 2002 there was an attempt to requisition the unit, designed and funded to provide acute in-patient services for the new conjoint counties of Carlow and Kilkenny, for short-term usage for medical beds while improvements and extensions were being made to the existing medical provision in St Luke's. The Inspectorate played some role in retaining the unit for psychiatry, on the understanding that the unit would open for psychiatric purposes as intended in early 2002. Our disappointment was considerable when this had not happened, for reasons that we never fully understood, by the end of the year.

Secondly, we were again disappointed when, on the completion of the unit at Portlaoise General Hospital midway through the year, we learnt that it was to be taken over for other purposes for a limited period of time, which would, however, run into 2003. Finally, although ready and handed over, the unit at Castlebar Regional Hospital had likewise not opened by the end of the year. In most of this, as in much else besides, the slow rate of

progress was a constant irritant and the interminable preludes of nursing union negotiations constantly slowed down progress always, of course, to patient disadvantage. Most notably, the “movement money” requested before staff would move from the old psychiatric hospital to the new general hospital unit has time and again delayed the improvement of patient care sometimes for periods of two years. It should be borne in mind that the settlement package applied in all cases to all staff, not just to those who moved.

Other major frustrations encountered during the year included the lack of provision by local housing authorities of housing for the mentally ill and the associated difficulty of procuring community accommodation in the private sector because of supply and cost factors. As a result, many in-patients had to remain in hospital unnecessarily. Many service providers, including clinicians, appeared to us to be uncertain of the purpose and functions of day hospitals. This led to the building or purchase of premises that were manifestly unsuitable for their function; for instance, buildings that did not contain a room large enough to cater for acutely ill patients.

There still continues to be on the part of many psychiatrists and others difficulty in comprehending and effecting the benefits of community care in all its ramifications. This understanding or the lack of it leads to an over-reliance on in-patient care and a reluctance to move out into the community. Of course, matters are not helped by the lack of physical and human resources but there is an inter-dependence of these factors compounded by the difficulty in establishing multi-disciplinary teams.

FUNDING INEQUALITIES

The basis for the funding of individual services on a comparative basis has always been on historical rather than on scientific or epidemiological grounds, taking account of measures of population characteristics such as deprivation and disadvantage. One of the principal items not taken into consideration is the number of catchment area persons holding medical cards on the one hand and those utilising private services on the other. When budgets to population in various catchments are calculated, discrepancies as high as fivefold emerge. In general terms, services in the eastern region suffer most in this matter of differential funding, although within the ERHA itself, there are considerable discrepancies, with inner city and disadvantaged suburbs doing badly by comparison with two services in the south of the region with low levels of medical card holders faring much better. For example, the level of medical card holders as of September 2002 showed considerable variation — from 23.68 per cent in Co Kildare to 49.12 per cent in Co Donegal. The figure for Dublin City and County at 25.46 per cent conceals much variation within catchment areas in the Dublin region. However, in interpreting expenditure data on a per capita basis across catchment areas, it must be borne in mind that gross figures do not take into account historical factors such as that many services are still maintaining an old mental hospital, however reduced in size, and that in the cost figure is the budget for, in some areas, many elderly and some intellectually disabled persons still resident in them, while in some more recently established services there is no such legacy of the past. A more appropriate basis for comparison would be the cost of acute in-patient and community services, but such data are generally unavailable. Of course, this is always a

difficult matter to change, in that the distribution of limited funding necessarily entails the taking from some to give to others.

Another approach to the problem is to re-align catchment areas, to equalise their size or equalise social and economic deprivation between them by re-drawing boundaries. This is difficult because it may mean crossing county or health board areas of responsibility.

HOMELESSNESS

One of the most central difficulties facing the mentally ill, and those tasked with providing for them, is the fact that many are or become homeless. Homelessness leads to rupture of contact with services, to petty criminality, contact with the law enforcement agencies and, apart from the damage to patients, gives community care a bad name. With the increase in mobility of young persons and greater co-morbidity of major mental illness with substance abuse, the numbers of abodeless mentally ill has almost certainly increased. It therefore becomes of vital importance that this problem is tackled on two main fronts: by providing housing and by outreach services from psychiatry working in concert with housing and other relevant agencies. It should also be borne in mind that, as well as the visible homeless, there are all too many who remain in various elements of residential services, not only occupying acute beds but also frustrating rehabilitation endeavour because, while being perfectly ready for community placement, there is nowhere for them to go. The task of acquiring housing for this group of persons is a challenging responsibility linked in the public sector with housing policy generally and the lack of a specific commitment either on a statutory or other basis to housing the mentally ill. Voluntary groups have done much in this field by availing of Department of the Environment contributions to provide some excellent hostels around the country. Nevertheless, much still remains to be done on this front. In the eastern region, the Northern Area Health Board has approval for a second consultant-led team specialising in delivering care to the homeless, exemplifying the second important approach to the problem in large urban areas.

TRANSFER OF PATIENTS WITH AN INTELLECTUAL DISABILITY FROM PSYCHIATRIC HOSPITALS

This on-going programme aims to provide more appropriate care settings and enhanced levels of services for persons with an intellectual disability, and those with autism, currently accommodated in psychiatric hospitals. In April 2002, there were 197 intellectually disabled persons in psychiatric hospitals (apart from those in St Joseph’s service, at St Ita’s Hospital) and a further 359 in de-designated units on the campus of psychiatric hospitals, and 344 in other services following transfer from psychiatric hospitals.

Over the years, the Inspectorate has regarded the practice of continued care of intellectually disabled patients in long-stay psychiatric facilities as inappropriate and had recommended their transfer to appropriate services to enable them get the skilled and specialised care not generally available in psychiatric hospitals. Two hundred and fifty-one persons with an intellectual disability were accommodated in the specialised St Joseph’s Intellectual Disability Service on the St Ita’s Hospital campus, Portrane at the end of 2002. Thirty

residents had moved to purpose-built accommodation in Oldtown, Co Dublin, and planning was at an advanced stage for a similar bungalow-type complex on the hospital campus to accommodate a further sixty residents, and to provide new day services for persons with autism. An application for planning permission in respect of this new complex had been submitted by the Northern Area Health Board to the local Fingal Planning Authority, and work was scheduled to commence in 2003.

The development plans for the Northern Area Health Board for the next number of years provide for the transfer of the remaining residents in the St Joseph's service to move from the old building in St Ita's to more appropriate accommodation, which will include both refurbished and purpose-built accommodation. The St Joseph's service is administered as part of the overall psychiatric service but it is the Inspectorate's position that a separate and reinforced administration, with enhanced clinical specialisation, is necessary to optimise the service available to this needy group.

In the Midland Health Board, a project team has been established to plan and implement a programme to enhance the level of services available to persons with an intellectual disability and to provide alternative placements for all patients accommodated in St Fintan's Hospital, Portlaoise and St Loman's Hospital, Mullingar, in addition to those at the Mount Alvernia (fifty-one persons) at Portlaoise and Lough Sheever Centre (seventy-two persons) on the St Loman's campus and at St Peter's, Castlepollard, where there were ninety-four persons. The Project Manager will oversee the implementation of this programme and a number of properties have been purchased.

In the Mid-Western Health Board, thirty-six residents were transferred from St Joseph's Hospital, Limerick to the Daughters of Charity service at Lisnagry in 2001 and plans are currently being prepared for the remaining twenty-four persons in St Joseph's Hospital to follow suit. During 2002, twenty-five persons who were accommodated in the St Paul's Ward of Our Lady's Hospital, Ennis were transferred to alternative accommodation at Spanish Point.

The North-Eastern Health Board was in the process of concluding discussions in relation to the transfer of twelve of the remaining eighteen persons with an intellectual disability in St Brigid's Hospital, Ardee. The six patients remaining are elderly and would be more appropriately placed in services for the elderly. The de-designated unit, Clogher House, on the grounds of St Davnet's Hospital, Monaghan accommodated thirty-six persons and there were discussions under-way relating to the transfer of fifteen of those persons to more appropriate accommodation.

There were ten persons with an intellectual disability in Sligo and Letterkenny hospitals all of those were elderly. Discussions were taking place in relation to the provision of appropriate care for them within the services.

In the South-Eastern Health Board, there were ninety-five persons with an intellectual disability in psychiatric hospitals. Twenty-one persons were moved from St Canice's Hospital, Kilkenny to new purpose-built accommodation during 2001 and a similar facility

for the twenty-one persons in Kelvin Grove in St Dymphna's, Carlow, was at an advanced stage of planning. No decision had been made relating to the intellectually disabled persons currently residing in two wards of St Senan's Hospital, Enniscorthy and in St Luke's Hospital, Clonmel.

In the Southern Health Board, twenty-nine of the forty-five persons with an intellectual disability moved from accommodation in St Finan's Hospital, Killarney, to purpose-built facilities in the town and there were plans to re-locate a further six to community facilities. The remaining patients in St Finan's Hospital and in the Board's other psychiatric hospitals were elderly.

The Western Health Board had twenty-six persons with an intellectual disability in psychiatric hospitals. Ten persons moved from St Brigid's Hospital, Ballinasloe and St Mary's Hospital, Castlebar, to community-based facilities. Discussions were to take place with the board in respect of the remaining twenty-five persons with an intellectual disability in St Brigid's Hospital, Ballinasloe.

MENTAL HEALTH SERVICES FOR THE INTELLECTUALLY DISABLED

There is a strong feeling among those providing services for the intellectually disabled that this group is not receiving optimal treatment for co-morbid psychiatric illness which is particularly common among this group of persons, despite the number of consultants in post. The principal difficulty is that the services and consultants are not integrated with mental health services generally and, as a consequence, they and their patients do not have access to mental health facilities, such as acute units for the treatment of acute psychiatric illness. These difficulties are the result of separate and non-integrated health deliverers providing care through services and staff that are not part of mainstream mental health services. Attempts should be made to bring together the various groups involved in an attempt to work towards a more co-ordinated approach to rational service delivery.

CONSUMER PARTICIPATION

It is increasingly important that consumers be involved both in the planning and delivery of services. It is equally imperative that patients be a party to their own treatment. This implies not only that they be fully aware of the nature of their treatment, its aims, purpose and likely outcome but also its side effects and any measures available to offset them. All of this information must be delivered in a manner that is intelligible, preferably by the patient's consultant taking into account all the necessary ingredients that together comprise informed consent. Where a patient, through severity of illness, does not have the capacity to participate fully or the comprehension necessary for such informed decision-making, then proxy representation by a relative or advocate will be required. It is of particular importance that medical case notes record that these processes have been gone through in each case. On each visit of inspection the Inspectorate discussed with patients their experience of the service provided for them and their views as expressed were included in each individual report.

The matter of consumer participation in planning and delivery of service is one that each health board and service should address. On the advocacy front, the Inspectorate is happy

to record that there has recently been considerable progress with the formation of a National Advocacy Network and with the representation of the consumer voice on the Mental Health Commission.

MATTERS OF DOCUMENTATION

The Inspectorate remains unhappy with the general level of documentary recording in our mental health services. Too often, case record structure is extremely poor with the record disorganised in every possible way, without sequence, and with missing information of the most fundamental nature. Consequently, it is often impossible to ascertain the date of a patient’s admission to, or discharge from, in-patient care or from the case notes to determine a patient’s legal status. Furthermore, the date of the making of a temporary patient reception order is often not apparent from the record so that there is no clear indication when that order should be extended or renewed. To worsen matters, as likely as not there will be no entry indicating that the order has been extended and why, on clinical grounds, it was deemed necessary to renew or extend the involuntary order rather than convert to voluntary status. A further omission, in many instances, is the lack of a space for the recording of an ICD numerical code for diagnosis or where it does exist, failure to complete it. This is a serious matter, *inter alia*, for those attempting to compile the returns for the National In-Patient Reporting System. It is vitally important that the top sheet of the patient record contain all the basic administrative information relating to each patient. In most cases, the written medical record gives no indication that a multi-disciplinary evaluation of the patient’s clinical and social circumstances has taken place shortly after admission to care and no record of a planned programme of care. Finally, if it is not recorded in the case note, then legally it has not happened!

There is then, we feel, a lack of discipline in the approach to and practice in these matters — partly a cultural phenomenon but, to the extent that training influences the culture of practice, a shortcoming of training. However, the Irish Psychiatric Training Committee would do well to encourage trainers to distribute copies of the World Psychiatric Association’s International Guidelines for Diagnostic Assessment (IGDA) to trainees.

MEDICAL STAFFING

There has been a substantial increase in consultants in psychiatric services largely brought about by the growth of sub-specialties as detailed earlier in this report. At the end of 2002 there were 276 consultant posts compared to 185 in 1991, an increase of forty-nine per cent.

However, medical recruitment to psychiatry has been falling in other jurisdictions and, while matters here are satisfactory for the time being, a falling number of recruits to the training schemes may herald difficulties to come. Current training is that set up by the Royal College of Psychiatrists of the United Kingdom and tailored to the needs of that jurisdiction and implemented by the Irish Psychiatric Training Committee. It may be that something more appropriate to our indigenous needs is called for. The impact of the Health Strategy and Task Force on Medical Manpower in relation to the aspiration to

provide consultant-delivered care through an increase in consultant numbers with a corresponding decrease in non-consultant hospital doctors and the European Directive on the reduction of their working hours remains to be seen. Other issues bearing on medical staffing include whether it is desirable, as is currently the case, that every psychiatric service in the country should be a training centre or that a degree of centralisation should operate, particularly given the difficulty some have in recruiting junior medical staff. Recognising that increasingly medical graduates are female, a greater need for more flexible working hours and job-sharing arrangements is called for. The matter of a sub-consultant grade doctor or career grade doctors in mental health services, although not meeting with professional favour, may be an issue that at some future time will need re-visiting.

The Inspectorate is concerned at the inroads made on consultant time by the sharp increase in the promotional activities of pharmaceutical companies, some in out-of-state jurisdictions and of several days' duration. While some meetings are educational and instructive and qualify for Continuing Professional Development purposes, others appear to present unscientific material aimed at influencing prescribing practice. All of course, influence the amount of time medical staff can spend with their patients.

NURSING

In December 2001, the steering group for the study of Nursing and Midwifery Resource, commissioned by the Department of Health and Children, published a guidance document, which included the set of principles fundamental to the development of transcultural nursing and midwifery. The report, which was issued as a resource for employers, contained a set of recommended best practices in relation to recruitment, induction, orientation and adaptation of overseas nurses into the Irish health care system. It is noted that only fifty-nine overseas nurses registered in the psychiatric nurses division of the nurses' register maintained by An Bord Altranais for the years 1999 — 2001 as compared to 5,006 registrants on the general nurses' register.

In July 2002, the Minister for Health and Children published the final report of the nursing and midwifery steering group entitled "Towards Workforce Planning". This was the first large-scale work undertaken with a view to setting out a comprehensive approach to nurse workforce planning. There were 11,511 nurses on the psychiatric division of the nurses' register maintained by An Bord Altranais in December 2002, but not all of these were employed in the health service. Nurses not in employment had opted to pay the annual retention fee and thereby maintained their name on the active file of the register.

Of interest to the mental health services is that half of qualified psychiatric nurses are over age forty-five years. Projecting forward to the year 2007, over sixty-five per cent of psychiatric nursing personnel will be aged forty-five years or over and only fourteen per cent under the age of thirty-four years. With the retirement age of fifty-five years possible for the majority, this is a matter of concern for services. There is an urgent need to ensure recruitment of a large number into the profession to meet present and future demands. Whilst the numbers entering psychiatric nurse training has increased from eighty-three nationally in 1998 to 342 in 2001, it is essential to keep this vital aspect of manpower

planning under constant review to ensure an appropriate supply of suitably trained psychiatric nursing personnel to meet present and future service needs.

The Report of the Commission of Nursing (1998, para 7.63) recommended that the Department of Health and Children, Health Service Employers and nursing organisations examine opportunities for the increased use of care assistants and other non-nursing staff, and also explore the development of appropriate systems to determine nursing staffing levels. A working group, with representatives of nursing unions and health service employers, as well as officials from the Department of Health and Children, was established to address two very important recommendations of the Commission on Nursing relating to the effective utilisation of the professional skills of nurses and midwives. One recommendation was that the health service providers and nursing organisations examine opportunities for an increased use of care assistants and other non-nursing staff. The working group recommended that the grade of Health Care Assistant be introduced as a member of the health care team, to assist and support the nursing and midwifery functions. The recommendation of this report has been endorsed by the Minister for Health and Children and the Inspectorate, as it marks a genuine step forward for the nursing profession, for health care assistants, and for the health service as a whole.

The nursing shortages being experienced by health service employers, particularly in the Eastern Region, have been addressed in some part through the recruitment of nurses from abroad. This is a short-term effective strategy. However, it should be noted that there is a global shortage of nurses, and countries experiencing shortages are competing with one another to attract nurses, and it is likely that this competition will intensify in future years. While it is still envisaged that recruitment patterns of this nature will continue in the immediate future, there is an urgent need to ensure annual adequate intakes of psychiatric nursing students to ensure that an adequate supply of home-grown locally-trained psychiatric nurses is available for registration. Allowances should also be made for student nurses who discontinue training, or who fail to register post-qualification. The total number lost to registration during the 1990's was eighty. Nurse staffing difficulties confronting the Irish health care service mirror the situation in other countries, where a shortage of nurses has been a feature of life for many years. Experience in other countries indicates that there is no simple solution, and that a multi-faceted approach is required. Such an approach must involve a critical examination of the manner in which the professional skills of a reducing supply of psychiatric nurses are utilised. The Commission on Nursing highlighted the increased need for personnel to perform non-nursing tasks, which had previously been carried out by nurses, and the Commission also noted the increasing number of care assistants and other non-nursing personnel employed in patient care areas.

For a country that historically has had an abundance of nurses, the recruitment difficulties experienced over the past number of years are unprecedented. The change in the status of student nurses in the 1990s, and the replacement of their service contribution, and the reduction in the training places in the late 80s and early 90s, with a total absence of psychiatric nurse training in many health board hospitals during the same period, has contributed significantly to the difficulties now experienced.

During 2002, the Government-approved sponsorship scheme for experienced care assistants was introduced, with up to forty sponsorships available. Successful applicants continue to be paid their normal salaries throughout the four years for 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 sponsorship scheme is a new initiative developed in an attempt to recruit and retain nurses in our public health care system.

NURSE STAFFING SKILL MIX

Any objective viewer of the Irish mental health service could not fail to be struck by the sophistication of the nurse training and the mundanity of everyday practice in some nursing activities despite training for much higher-level work. Too often, it seemed, that nurses were engaged in tasks below their level of expertise such as staffing community residences, particularly at night and often in unnecessarily large numbers, where they have little opportunity to deploy their expensively acquired skills. In all these circumstances, nursing assistants with appropriate training and supervision could just as easily perform the required tasks, leaving nurses free to work at a higher level professionally. There does appear to be an irrational fear of relinquishing any task currently and historically carried out by nurses in an era of less complex mental health care organisation when, now, there is a crying need for much greater and more sophisticated work in community outreach settings. The current shortage of nursing personnel, particularly in some areas of the country, should sharpen minds in this regard.

OTHER PROFESSIONALS

The continuing shortage — in some cases, complete absence of — psychologists, social workers and occupational therapists in our services is an intolerable restriction on the nature of service delivered and makes multi-disciplinary working impossible. The difficulties stem, in part, from lack of training places — particularly so in the case of clinical psychology — and also from fear of professional isolation in a field where traditionally doctors and nurses predominated.

SUDDEN DEATHS AND SUICIDES

There were nineteen sudden in-patient deaths during the year. While post-mortem examination revealed that most of these were due to natural causes, in one case the level of a psychotropic drug present was regarded as of toxic level, another death was due to aspiration of food material in a patient with deficient swallowing capacity and in another case the post-mortem examination was inconclusive as to cause of death. Clinicians should bear in mind that some psychotropic drugs have the capacity to induce fatal cardiac arrhythmias and carry out appropriate tests on individuals who they think may be medically compromised before prescribing these drugs, having obtained fully informed consent before doing so.

There were thirteen suicides, or suspected suicides, during the year of patients “on the books” in 2002; of these nine were in the hospital or its grounds, three were by patients who were on authorised leave and one by a patient absent without leave. It should be pointed out, that inquests in relation to such deaths are not always held in the same year

as the death itself, and therefore, the number in any Inspector's report refer to those deaths that, on clinical grounds, appear to have been suicide, rather than legal suicide as determined by the coroner. The Inspectorate is of the view that formal audit procedures should be carried out in each case of suicide or suspected suicide among in-patients and the Inspectorate will issue guidelines in the matter shortly. The number of out-patients committing suicide is unknown, and although some services do report suicide among out-patients there is no legal obligation on them to do so. Nevertheless, there is much merit in having these cases where they are known, reported to the Inspectorate. It would be helpful if the psychiatric services were to report details of known cases of suicide by patients, (other than patients in in-patient care), to the Inspectorate and the National Suicide Review Group.

MATTERS LEADING TO ENQUIRY

During 2001, a patient in the CMH died shortly after being restrained. The matter was, during 2002, the subject of Garda investigation. This investigation has now concluded and a file is with the Director of Public Prosecutions. An investigation into an allegation of sexual abuse of a female patient in the CMH has concluded with the dismissal of a staff member. During 2002 the North-Eastern Health Board reported the results of an enquiry it had set up into the contacts made with the Louth psychiatric services of a young man who killed his nephew. The report made recommendations directed at improving communication between the Louth service and general practitioners. In particular, it pointed out the delay in re-arranging failed out-patient appointments and the long waiting list for appointments in the South Louth sector. A Tribunal of Enquiry (the Barr Tribunal) was established by the Oireachtas on the 17th and 18th April 2002 to enquire into the facts and circumstances surrounding the fatal shooting by the Garda Síochána of a young man, John Carty, with a history of mental illness and to make recommendations. The Tribunal will be dealing with the mental health issues relevant to the matter.

OTHER ACCIDENTS, INCIDENTS AND ASSAULTS

The Inspectorate enquired into the number of accidents, incidents and assaults on patients and staff on each visit of inspection. Details of recorded accidents, incidents and assaults were included in individual service reports.

PROVIDING INFORMATION TO PATIENTS AND RELATIVES

In the course of our inspections in 2002, it was noted that most, but not all, services had information notices or patient information leaflets, outlining rights under the Mental Treatment Act, 1945 and amending legislation. Speaking to patients it became clear that many patients were not aware of their rights or aware of how to make a complaint if they felt aggrieved. In individual reports, the Inspectorate made comments and recommendations relating to the provision of certain information, especially to detained patients, about their circumstances in relation to detention, consent to treatment, rights of appeal and other pertinent matters, as soon as practicable. Ideally, the name of the person giving the information, the date the information was given and a note whether the patient understood the information should be recorded in the clinical notes.

COMPLAINTS

The 1945 Act allows for patients to complain directly to the Minister for Health and Children, the President of the High Court and the Inspector of Mental Hospitals. In practice all such complaints and grievances make their way to the Inspectorate. Most concern involuntary detention, complaints about treatment or conditions in hospitals or units. Each is investigated with the senior medical and other relevant staff of the service concerned and the outcome of the investigation communicated to the patient or relative involved. Where it seems warranted, patients are visited and interviewed individually.

“CITIZENISATION” OF LONG-STAY PATIENTS

It is essential that those suffering from mental illness, particularly illness that is enduring and on-going, should enjoy and practice the full rights and privileges of citizenship. We are not convinced that this is always the case. For example, it is our impression that few long-stay patients, whether in hospital or in community residences, are on electoral registers and vote in elections. We would urge staff to do their utmost to right this situation and, in each service, to survey the current situation in this regard and remedy it. We would like that staff insist, in matters of general health care, patients are not discriminated against because they are psychiatric patients. Staff should be vigilant to ensure that patients have access to the full range of preventive and curative health services as everyone else. We are not aware that long-stay patients have participated in Breast Check in those areas where this service has already become available. We have heard of instances where general medical and surgical consultants have refused to admit patients to their beds unless a psychiatric nurse accompanies them from their parent hospital, even though this is completely unnecessary clinically. We have also been told, and seen instances, where intellectually disabled, and sometimes others who have difficulties in feeding themselves, have been transferred to general hospitals and have been the subjects of percutaneous endoscopic gastrostomy or “peg feeding” (food being delivered directly through the stomach wall by tube) because general hospital staff have considered they have not had the time to spoon feed dependent and disabled patients. Some of these patients have returned to their psychiatric locations with the mechanism still in place.

Services should, as far as possible, reduce paternalism and foster independence and encourage self-reliance in patients. Too often, for example, little effort is made by staff to encourage patients living in group homes to manage the day-to-day affairs of the home, such as opening independent bank and rent accounts.

DISABILITY ALLOWANCE FOR THOSE IN RESIDENTIAL CARE

Responsibility for the Disabled Persons Maintenance Allowance (DPMA) Scheme was transferred from the Department of Health and Children and the Health Boards to the Department of Social, Community and Family Affairs in October 1996. On the transfer of this scheme, the existing qualifying conditions were retained and the scheme was re-named Disability Allowance. One of the qualifying conditions applying to the former DPMA Scheme was that the payment could not be made to people who were in residential care or in hospital. People in these situations had their maintenance costs and, in certain cases a limited amount of pocket money met through funding from the Department of

Health and Children and the appropriate health board. The disqualification under the DPMA Scheme can be traced back to the operation of the Poor Laws in Ireland. Originally the assistance provided under the Poor Law System was in the form of institutional relief for the sick and destitute poor. Gradually the restriction on the provision of relief only in an institution was eased, and outdoor relief was introduced. The Public Assistance Act of 1939 replaced the Poor Law System with a system of Public Assistance, which included medical assistance and general assistance. The Health Act of 1953 provided for the introduction of Maintenance Allowances for Disabled People aged sixteen and over who were unable to provide for their own maintenance. However, people who were being maintained in institutions or hospitals were not eligible for this allowance. The DPMA Scheme therefore replaced Home Assistance for people with disabilities living in the community. There are a number of people within the mental health system, particularly those in long-term residential care, who are entitled to Disability Allowance. Most of those patients receive “pocket money allowance” under Article 13 of the Mental Treatment Regulations (1961) — now referred to as spending allowance for persons in long-stay institutions. Whilst the Department of Social, Community and Family Affairs have relaxed the restrictions since 1997, nevertheless, there are still a large number of people not in receipt of disability allowance. There are plans to ensure that people with disabilities will be treated on an equal basis to other categories of social welfare recipients and, in time, it is hoped that all people in residential settings will have a legal right to Income Support as opposed to the current discretionary arrangements. This will be in line with the aim of achieving equal citizenship for all people with disabilities where payments will be made to all eligible people regardless of their residential status.

DIET AND CIGARETTES

Although matters are improving, particularly with more and more care being provided in general hospital units, the Inspectorate would like to see more fruit and vegetables included in menus, particularly at the evening meal. Too often, fare appears to centre around fried foods exclusively. We would, too, welcome the regular appearance of changing menus and the distribution and display of these menus in dining rooms. We have commented in the past, on the practice of providing the evening meal as early as 4.30 in the afternoon and, more worryingly still, the administration of the evening medication at this time also which makes a nonsense of the ideal of maintaining an even level of blood drug levels over the 24-hour period. There still persists in some services the practise of distributing of cigarettes gratis as a “benefit in kind” to patients. We discourage this practice and are happy to record that it has ceased in the Central Mental Hospital.

Each service should have a smoking policy. Non-smoking should be the norm in all hospitals, units, community residences and clinics, except in specifically designated smoking areas, which should be clearly identified at each location. It was noted that some services have community residences that are totally non-smoking and residents who smoke comply with the house rules on smoking in a designated area outside the building. The circular “Smoking and Health”, issued by the Inspectorate, which recommends the provision of designated smoking areas with all others smoke-free and a discontinuation of the practise of distributing tobacco products to patients, will be re-issued during 2003.

THE USE OF CLOSED CIRCUIT TELEVISION (CCTV)

The Inspectorate concedes that the use of CCTV may be a useful adjunct to clinical observation in the case of patients placed in seclusion. However, we are concerned that any more widespread use, as is the case in a minority of services, is a serious invasion of personal privacy and dignity. Equally, it should be realised that its use should never replace the clinical skills of personal observation that, because of the human interaction involved, is in itself therapeutic.

EUROPEAN COMMITTEE FOR THE PREVENTION OF TORTURE AND INHUMAN AND DEGRADING TREATMENT OR PUNISHMENT (C.P.T.) AND FORENSIC PSYCHIATRY

The European Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment visited Ireland during 2002. This Committee is a multinational body of experts, set up with the right to examine the treatment of persons deprived of their liberty.

The Committee was established under the terms of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment in 1987, and is based in Strasbourg. The Committee met with the Inspectorate and policy-makers in the Department of Health and Children prior to their visit of inspection. Three members of the CPT visited the Central Mental Hospital on 21st May and St Ita's Hospital, Portrane on Saturday, 25th May, 2002. The visit to St Ita's Hospital focussed entirely on the St Joseph's Intellectual Disability Service, where six units were visited in the morning and the delegation revisited the two Challenging Behaviour Units again in the afternoon. Four members of the CPT visited St Raphael's in Youghal on 24th May 2002 and Grove House in Cork on 25th May 2002. Both services are for the Intellectually Disabled and are not designated under the 1945 Act. The report of these visits was presented to the Irish Government and a response will issue in 2003.

While generally complimentary about patient care in the CMH, the Committee was critical of the frequency of, and the conditions under which, seclusion was effected in the CMH, thereby echoing the criticisms of the Inspectorate, repeated year after year. Other unsatisfactory aspects of care in the hospital include the lack of in-room sanitation with the consequent slopping out procedure each morning. However, during the year, an advisory group on the future of the CMH was set up and drew up a modernisation plan for the hospital involving very considerable capital expenditure, which if implemented would rectify most of the current difficulties of this building which remains substantially unmodified since its provision in 1845.

In concert with the Inspectorate the CPT also deplores the lack of occupational and rehabilitatory activity in the CMH and also the need for community-based services for this group of patients.

Concerning St Joseph's Intellectual Disability Service, the Committee had only one major criticism to make and that was to deplore the complete absence of psychological services.

SECTION 208 OF THE MENTAL TREATMENT ACT, 1945

The use of Section 208 of the Mental Treatment Act, 1945 to transfer patients from their parent hospitals or units to the CMH continues, there being six such transfers during the year. In many instances, the Departmental guidelines issued by the Inspectorate were not followed and, in some cases, even more serious disregard for statutory provisions relating to legal admission procedures were detected. It is worth noting that some Section 208 residents have been retained in some cases for several years, contrary to the spirit of the section, which envisaged short stays for intensive treatment.

THE MENTALLY ILL IN PRISONS

The CPT, in its recent visits to Irish prisons, sharply criticised the placing of mentally ill prisoners in padded cells. In response, the Departments of Justice, Equality and Law Reform and of Health and Children were in the process of drawing up a service level agreement to enable such prisoners be transferred to the CMH as quickly as possible. At the same time, the forensic psychiatric services have been strengthened by the imminent appointment of three further consultants in the Eastern Region, bringing the total to five. The provision of two special interest posts, one in Cork and a second in Limerick, were being negotiated with the relevant health boards.

THE CRIMINAL LAW (INSANITY) BILL

Towards the end of the year, the Department of Justice, Equality and Law Reform produced its long-awaited Criminal Law (Insanity) Bill. This would give courts greater powers and discretion in referring persons brought before them and believed to be mentally ill to treatment facilities and, in the case of capital charges, allow for the verdict “not guilty by reason of insanity”, embodying the new concept of diminished responsibility by reason of mental illness. This Bill when passed into law will provide an independent review process for those CMH patients detained through the criminal justice system of persons adjudged “unfit to be tried” or “not guilty by reason of insanity” a relief not currently available. However prisoners transferred to the CMH on other grounds will not come within the ambit for the review process provided for under this legislation.

RISK ASSESSMENT AND MANAGEMENT

The Inspectorate, over the years and in the Guidelines on Good Practice 1998, has emphasised the importance of clear policies and procedures to protect both patients and staff, and the need to introduce a monitoring process to ensure that all policies are adhered to. This is the first step in a formal approach to risk management, where there is a proper assessment of all risks and the devising of appropriate strategies to minimise them in every area, whether relating to the ward environment, health and safety issues or the care of patients. Whilst some services had updated their health and safety policies and had conducted periodic safety audits, many had outdated policies and procedures.

Risk assessment should not be a paper exercise, rather it is a tool to enable staff and patients feel safe and to ensure a truly therapeutic environment is maintained at all times.

Whilst risk assessment and risk management are relatively new issues in the context of Irish mental health services, the Inspectorate recommends that all services adopt a stringent and proactive risk management culture in all units.

MANAGEMENT OF AGGRESSION AND VIOLENCE

All staff working in the mental health service had access to training in the management of aggression and violence. However, the content of training courses and the extent of training varied widely. As mentioned in previous reports, the Inspectorate has concerns relating to unregulated training courses and, in order to ensure some uniformity of approach throughout the country, has recommended that a set of approved national training standards be introduced and validated by a national training authority. All staff should be adequately trained and competent in the use of a de-escalation approach for the handling of potentially violent situations and in breakaway techniques in relation to patients' safety. All attempts to restrain aggressive behaviour should be non-physical and, where physical restraint is used, it should only be as a last resort.

THE GARDAI AND MENTAL HEALTH

By reason of their fundamental community involvement, the Garda Síochána are first-line community agents and, as a consequence, encounter persons with mental health problems almost on a daily basis, yet up to now had no formal training in principles of mental health or on service availability or contactability. It is therefore heartening to report that, following discussions between the Department of Health and Children and An Garda Síochána, a mental health module will be introduced into the student Garda training programme in 2003. Thereafter, it is to be hoped that there will be improved communication and mutuality between the mental health services and the Gardai to replace the former distrust between the two. This is all the more important in the light of the proposed further development of forensic psychiatric services.

PATIENT ESCORT WORKING GROUP

This Working Group, which included representatives of all of the interests involved in the escorting of patients to hospital, was established in 2001 to review the practice of patient escorts in the context of future development of mental health services and, in particular, the provisions of the Mental Health Act, 2001 and to make recommendations in relation to future practice. The Group finalised its report towards the end of the year but this had not become available before the end of 2002.

TASK FORCE ON ASSAULTS ON PSYCHIATRIC NURSES

During the year, the Minister for Health and Children established a Task Force to examine the incidences of assaults on nurses, and the level of injury arriving therefrom, to investigate the reasons for such assaults, with a view to putting in place effective preventative measures and to put forward proposals for an appropriate compensation scheme for nurses injured through assaults at work, such proposals to have special regard to the position of

psychiatric nurses. This Task Force has an independent chairman and includes representatives from the Department of Health and Children, Department of Finance, Health Service Employers' Agency, nursing management, and nursing representative bodies. The report from the Task Force was awaited.

GUIDELINES ON GOOD PRACTICE AND QUALITY ASSURANCE IN MENTAL HEALTH SERVICES

In 1998, the Inspectorate issued a guide to those practising in mental health services with the above title. The guide attempted to highlight those matters that, in the course of inspection work the Inspectorate perceived to need attention in the delivery of a service of quality. The Inspectorate had come to realise that, in the course of professional education, little emphasis was placed on issues of fairly fundamental importance in service delivery. We are concerned with three basic areas where the educational process falls short. First, there is the matter of respect for and understanding of the medicolegal necessity for good clinical record-keeping, apart altogether from it being primarily a matter of good practice. In the section on documentation in this report, we have already referred to the items that most concern us in this field; here we ask that clinical teachers do their best to improve matters, not least by example, through creating a mindset whereby good practice in these matters becomes incorporated into the culture of good clinical practice.

Our second general area of concern is that relating to communication with patients and relatives. This is obviously important in all areas of medical interchange but particularly in psychiatry. Too often, complaints reaching the Inspectorate from patients and relatives stem, not from any clinical failing, but rather from failure on the part of clinicians to ensure that patients and their relatives are fully informed and comprehend the nature and purpose of their treatments. Our service visits and our interviews with patients confirm that there are shortcomings to be remedied in these matters. This poses a challenge to senior clinical teachers, some of whom may have something to learn in this respect themselves. The third area of worry to us is the lack of any systemised approach to teaching the elements of Irish mental health legislation to psychiatric trainees, in part because the qualifying course and examination are designed and conducted by a body operating outside the national territory and within its own different administrative and legal framework. However, with the imminent coming into place of the Mental Health Act, 2001, provision is promised for explanatory and training sessions to be set up on a nation-wide basis to ensure that the theoretical and practical aspects of the Act are thoroughly understood by all administrators, practitioners and others likely to be involved in its operation. It will, of course, be essential that this be an ongoing process and that teaching modules incorporating it will form part of all training programmes.

CLINICAL TRIALS AND INFORMED CONSENT

On each inspection, the Inspectorate enquires into any research being carried out that comes under the Clinical Trials legislation, whether the trial has been the subject of ethical approval and whether the guidelines laid down for such trials by the Irish Medicines Board have been followed. At this point, the Inspectorate is anxious to heighten awareness among clinicians to the increasingly complex and demanding issue of informed consent,

whether in the context of research participation or in the more ordinary circumstances of routine treatments. Under the provisions of the Mental Health Act, 2001 involuntary patients cannot be subjects in drug trials. It is worth pointing out that our enquiries indicated that there are very few drug trials being carried out in Irish Psychiatric services.

SECLUSION

On each visit of inspection, the Inspectorate enquired into the number of patients placed in seclusion, and the number of episodes of seclusion, and all facilities where seclusion was used were visited. Whilst seclusion registers were adequately maintained at all locations, it is recommended that all seclusion authorisations be signed by a consultant psychiatrist. Seclusion policies, procedures and guidelines, along with medical and nursing notes relating to randomly selected seclusion episodes, were examined and commented on in all services where seclusion was used. Records of the use of seclusion by health boards and individual hospitals including episodes of seclusion and numbers of patients secluded are included in an Appendix to this report.

SPECIAL NURSING OBSERVATION

Similarly, the use of special nursing supervision and nursing observation levels were enquired into on each visit of inspection. Comments and recommendations, if appropriate, were included in each individual report. Records of the use of special nursing by health boards and individual hospitals relating to episodes and numbers of patients placed under special nursing observation are included as an Appendix to this report.

ELECTRO-CONVULSIVE THERAPY (ECT)

As in other years, the Inspectorate monitored the use of this treatment and the facilities for its provision, together with the documentation of accompanying practices and procedures. It was noteworthy that, while the administration of this treatment has greatly decreased overall, there are considerable variations in its use from service to service.

THE MENTAL HEALTH COMMISSION

2002 saw the setting up of the Mental Health Commission with the appointment of the members and a chairperson. The Commission has three basic functions. The first is concerned with the automatic independent review of patients detained involuntarily under the provisions of the new Act through the mechanism of Mental Health Review Tribunals to be set up by the Commission. Under existing legislation (Mental Treatment Act, 1945), review is not automatic, although there is a requirement under section 237 of the MTA that the Inspector of Mental Hospitals shall “see each of the patients received since his previous visit required by this Act and inspect the documents authorising the reception of each such patient” — a manifest impossibility, given that the average length of stay prior to discharge is of the order of three weeks. It can be said, however, that temporary reception orders, including those pertaining to discharged patients are inspected and where irregularities are discovered, as they sometimes are, these are pointed out to staff. Under following sections, the Inspectorate is required to investigate cases “the propriety of whose detention he doubts” and must examine any patient who requests such examination or

when requested by any other person. Additionally, every patient, whether detained or not, has the right to write to the Minister, the President of the High Court and the Inspector about any matter. The second major function of the Commission will be the establishment of an Inspectorate, based within and reporting to the Commission on quality issues in mental health services, much as the current Inspectorate does. Finally as its third major function the Commission has the responsibility of establishing and maintaining a register of centres approved by it for the detention of patients suffering from mental disorder.

THE YEAR AHEAD

All the indications are that 2003 (and in all probability the following years) is going to be a difficult year, particularly on the capital expenditure side. Fortunately, the two new psychiatric units at St Vincent’s Hospital, Elm Park and James Connolly Hospital, Blanchardstown were almost complete by the end of the year and will be ready for occupation in 2003. Both of them will replace quite unsatisfactory acute admission units at Vergemount Hospital in the first case and the existing unit at James Connolly. Unfortunately, the retrenchment is likely to retard similarly urgently needed acute admission replacements at Wexford, Mullingar, Ballinasloe, Mallow and Dundalk.

Funding difficulties are also likely to impact on the provision of community residences for those with persisting disability from enduring illness and who require both supervised and unsupervised community residences and rehabilitation now that the large mental hospitals with their poor quality accommodation are both closed and closing. In the absence of this provision, it is inevitable that such patients will accumulate in acute beds clogging up the system.

On the revenue side, it is the Inspectorate’s view that greater value for money will be required by careful auditing of current work practices. In particular, far greater use of skill mix options should be pursued and more flexibility shown in matters of staff deployment.

The Health Strategy promised that a new Policy Framework for Mental Health would be prepared to plan the psychiatric services of the future, following in the steps of the Report of the Commission of Enquiry on Mental Illness in 1966 and of the Working Group, Planning for the Future, in 1984. It is anticipated that work will commence in 2003.

OVERVIEW OF REGIONAL SERVICES

EASTERN REGIONAL HEALTH AUTHORITY

SOUTH-WESTERN AREA HEALTH BOARD

This board provides three catchment area services, St Loman’s/Tallaght (Areas 4 and 5), St James’s (Area 3) and Kildare and West Wicklow (Area 9). At the end of the year, discussions between St.Loman’s/Tallaght and St James’s on the transfer of a population sector of approximately 35,000 persons from St Loman’s to St James’s in an attempt partially to redress the current threefold population imbalance between these two catchment areas, had reached an advanced stage.

At St Loman's, the new "Advanced" building opened in December on the campus containing the replacement rehabilitation unit and some administrative offices. This is a temporary building, pending the provision of a number of new separate units on the St Loman's land, including a rehabilitation unit, a high-support hostel and a unit for the elderly. With the closure of the old rehabilitation unit, the only patient-occupied part of the original hospital, the way will be clear for the demolition of the original structure.

A new day hospital and sector headquarters for the St James's service was being established on the South Circular Road for its northern sector. This will lead to the closure of the present unsatisfactory operation in the Jonathan Swift Clinic. Further community developments are planned for the southern sector. Most of the long-stay catchment area patients cared for in St Patrick's had been transferred to other locations in view of their ages, having become quite elderly. Overall, the service was strengthening its links with St James's Hospital and becoming less reliant on St Patrick's Hospital.

The psychiatric unit at Naas Hospital had extricated itself from a situation of overcrowding where extra beds were being accommodated in corridors, because the unit contained many persons not in need of acute care, through transferring them to the newly-opened community residence at Newbridge. Other residential accommodation is planned. A major shortcoming is the lack of a day hospital and headquarters at Naas itself, the largest centre of population, to complement the new premises at Celbridge and Athy.

THE NORTHERN AREA HEALTH BOARD

St Brendan's Hospital now contains fewer than 200 patients catering for part of Area 6, for acute admission purposes, providing four intensive care wards for the ERHA, a unit for the homeless and persons of no fixed abode, some of them newly arrived in the country, in generally unsatisfactory physical surroundings. The acute admission function for Area 6 will cease with the opening of the newly-constructed acute admission unit at James Connolly Memorial Hospital at Blanchardstown, although some long-stay patients in the St Brendan's admission wards will need alternative accommodation. Most of the St Brendan's campus has been acquired for educational purposes but, on the remaining land, the health administration will erect modern structures for special needs groups, such as the homeless mentally ill and a new intensive care unit. At this time, St Brendan's, as we have known it, will cease to exist.

The Area 7 service continues to operate with the major in-patient base at St Vincent's Hospital, Fairview, and supplemented by the small unit at the Mater hospital which caters for one of the Area 7 sectors. A new day hospital has been operating for over a year now at St Vincent's, with an outreach and home care orientation. There has been some upgrading, but further improvement of community facilities is required and, in the case of the Mater sector, the putting in place of a day hospital, sector headquarters and community residences, none of which currently exist.

St Ita's Hospital, Portrane has a dual function; it provides mental health services for North County and part of north Dublin city on the one hand and, on the other, intellectual disability services for all Dublin city and county under the same administration. There is

under-staffing, on the consultant medical side for the St Joseph's intellectually disabled service, limiting the community services available. There have been some closures of out-dated premises and upgrading of others at St Ita's mental health service and plans have been drawn up for the alternate and improved accommodation of long-stay patients, including the elderly. This initiative will proceed in concert with the activities of the newly-established rehabilitation team. Plans and designs of the acute unit for the service at Beaumont Hospital had been completed at the end of the year. For the St Joseph's service, the opening during the year of the new and extensive community residence near Swords and the transfer out of St Ita's Hospital of some thirty patients has been an exciting venture, hopefully soon to be replicated elsewhere in the service. Likewise in the mental health service, the recent acquisition of large premises in Balbriggan to replace cramped and inadequate accommodation in the same town to serve as day hospital and headquarters was eagerly awaited.

At James Connolly Memorial Hospital, Blanchardstown the current unit, which has been most unsatisfactory for its purpose, will shortly close and its functions transfer to the newly-constructed purpose-built unit at the same hospital. Adjacent to it will be the day hospital. Once the new unit begins receiving patients, none will be transferred to St Brendan's and the catchment area will become self-reliant for acute admission purposes, thus allowing the admission units in St Brendan's to close for acute care. A further occurrence in this service has been the acquisition of substantial premises in an industrial estate in Blanchardstown to operate as a day hospital and sector headquarters. A new service for the psychiatry of later life has been set up in this service with acute assessment beds to be established in the new unit and a service headquarters will soon become available nearby.

EAST COAST AREA HEATH BOARD

This Board contains three catchment area services. The first of these covers Area 2 and currently has its acute in-patient base at Vergemount Hospital, Clonskeagh. This is one of the former units of the fever hospital and is totally unsuitable for modern acute care. Happily, it will shortly be replaced by the new purpose-built acute unit at St Vincent's Hospital, Elm Park. This Unit will also replace the existing unit, St Camillus ward, St Vincent's Hospital, which, during 2002, was operating at very much reduced capacity of its limited bed provision because of staff shortages. It is to be hoped that the necessary negotiations between the heath board and St Vincent's administrations will proceed with alacrity and that the staff representative bodies will play their part in allowing matters to advance smoothly.

The Cluain Mhuire service, based in Area 1, operates as a catchment/one sector service with a centralised community base in Blackrock and its in-patient component at St John of God Hospital, Stillorgan. The day hospital for this service is also located in the Stillorgan hospital but the service would like to obtain a community base for it. The rehabilitation activity component is situated at Burton Hall in the Stillorgan Industrial Estate and is an impressive approach to training and skilling those with mental illness towards employment placement through a wide range of schemes.

Finally, the Co Wicklow service, based in its in-patient component at Newcastle Hospital, requires some further community developments in its mid and south sectors. It provides liaison services to Loughlinstown Hospital for Co Wicklow patients. It may well be that an acute unit for the county might be based here even though Loughlinstown is just over the county boundary in Co Dublin. This matter of redrawing catchment areas has been referred to earlier.

THE MIDLAND HEALTH BOARD

Here, there were two county catchment services, Laois/Offaly and Longford/Westmeath. In the former, the new acute unit at Portlaoise General Hospital was completed and commissioned during the year but was given to the general hospital for medical and other purposes while newer accommodation was being fitted out on the general side. There was a firm commitment that it would revert to its rightful occupants, the psychiatric service, by April 2003, whereupon the two admission wards in St Fintan’s Hospital would close. Thereafter, the task for the service will be to place the remaining elderly patients in St Fintan’s in alternative accommodation and to acquire a rehabilitation community-based unit for those in the current rehabilitation ward in St Fintan’s.

Despite some ward closures and improvements, there is still much that is unsatisfactory about St Loman’s Hospital, Mullingar. The renovation of the admission units was proceeding at a slow pace during the year and only one ward had returned to its upgraded premises, with the other, the female, being embedded in the heart of the old building. In any case, it is the Inspectorate’s position that, even in their improved state, these wards will never be ideal for modern admission purposes because of their structure and layout. The solution must lie in the provision of a purpose-built unit in Mullingar General Hospital. In addition to newly provided premises for day care activity at Mullingar and at Longford in recent years, attempts were being made to acquire new and extended accommodation on a generic health location at Athlone, to replace the current small and cramped allocation. Greater attention needs to be given to planning a more community-orientated approach to the delivery of care in this service.

MID-WESTERN HEALTH BOARD

In Limerick, many intellectually disabled persons have transferred to the specialised service at Lisnagry from St Joseph’s Hospital, allowing some wards to close. It was hoped that the remaining patients with this disability would soon follow to the same location, with further closures in St Joseph’s. It was reported that those who have already gone have improved substantially. A very suitable premises has been acquired at Clonlara, called Solus Eile, to accommodate elderly patients resident in unsuitable ward premises in St Joseph’s. Unfortunately, they had not moved by year’s closure because of protracted and unconcluded partnership negotiations. Meanwhile, further community developments were exemplified by the opening of a state-of-the-art day centre in Limerick City. There has been a new reluctance on the part of Gardaí to bring PUM patients to the psychiatric unit at Limerick Regional Hospital because St Joseph’s is still the district mental hospital. This, together with the practice of transferring a small number of patients from the unit to St Joseph’s, may delay its closure. A worrying aspect of the activity of the unit at the

Regional Hospital is its use for the admission of children under sixteen years of age deemed to be in need of in-patient care and, for whom there are no specialised residential acute care facilities (a national and difficult problem). During most of 2002, there were at any one time three such children (one as young as twelve) on the unit. Apart from many other problems which this causes, there was that of cost, as each of these children was individually nursed on a one-to-one basis, day and night.

Together with Cork, Clare has had the distinction of closing its nineteenth-century mental hospital, Our Lady's, Ennis, during the year, with its former residents moving to superior accommodation at a number of new locations, at Ennis itself, Kilrush and Spanish Point.

Recent years have seen the establishment of a specialised service for the elderly and just last year a new consultant-led rehabilitation team. At the same time, an outreach approach is being put in place in the Ennis sector and it was hoped to strengthen community and domiciliary involvement in the other sectors.

The Mid-Western Health Board had assumed responsibility for psychiatric services in Tipperary, North Riding and provided community services at Nenagh and Roscrea. However, in-patient accommodation for this population remained at St Luke's Hospital and St Michael's Hospital, Clonmel.

NORTH-EASTERN HEALTH BOARD

Here, there were three catchment area services: Cavan/Monaghan, Louth and Meath, each of approximately equal population size. While Cavan/Monaghan was managed as a single unit, the other services operated as a combined entity. Although this may be understandable in historical context, with Meath having been transferred from St Loman's, Mullingar to St Brigid's, Ardee on the setting up of the health boards, the later establishment of an independent mental health service for Meath with an acute admission unit at Navan General Hospital, surely warranted parity of autonomy with the other two services in this Board. This was not merely an administrative nicety; it also impinges on the rate at which the community development of services in this county can progress. It was, therefore, not surprising that, compared with the other services, that of Meath was poorly funded — particularly in relation to Cavan/Monaghan — and lacking in community and other assets. However, the Navan unit was functioning well, although lacking an occupational and recreational facility and currently, because of space limitations, unable to provide one. The day care provision at Dunshaughlin, while attractively located in a modern and expanding generic health and social centre, was too small and required enlargement. This was being negotiated and may provide the required sector headquarters and day hospital for this sector. Plans have been drawn up for a similar provision for new premises in Navan to replace or augment that available at present in the Infirmary. A sector location had been acquired in a centre-town situation in Kells. However, community residential accommodation was proving difficult to acquire in this sector. It is important that the means be allocated to this service to emulate in community activity and specialisms its fellow services in the Board.

In Cavan/Monaghan, where resources were far more abundant, much has been accomplished through two main endeavours, that of early intervention and community-based responsiveness to acute illness through the deployment of specialised teams, on the one hand, and by means of assertive outreach and home care to those with enduring psychiatric illness, again, through the training and utilisation of skilled personnel, on the other. The fruits of this orientation and practice can be gauged through the minimal requirement of acute admission beds now numbered in single figures, wastefully dispersed in two admission units, one at St Davnet's Hospital, which should be closed, and the other in Cavan General Hospital. The Cavan/Monaghan experience should not be without significance for progress in our other services, although not all may have the resources and the understanding and commitment to emulate it.

Encouragingly, a new high-quality community residence, purpose-built, accommodating about fifteen long-stay patients from St Brigid's Hospital, Ardee, opened in Dundalk during the year. It also had some respite capacity. At the same time, intellectually disabled persons were transferred to alternative and more appropriate specialised care. As a consequence, there were ward closures and amalgamations at St Brigid's Hospital. The challenge now was to proceed with a proposed new acute admission unit for the county at the Louth Hospital. The existing headquarters and day facility at the Louth Hospital will shortly be extended, something that was needed in its own right and not only because of the recent establishment of another consultant-led team in North Louth.

NORTH-WESTERN HEALTH BOARD

This Board had responsibility for catering for two mental health catchment areas — Sligo/Leitrim and Donegal. In Sligo/Leitrim, despite significant progress in closing the old St Columbas Hospital, moving acute admission and continuing care, together with the intensive care unit for the Board to the Ballytivnan Mental Health Centre, formerly the newer part of the St Columbas complex and the extensive provision of community residential accommodation, no progress had been made in building the acute admission unit at Sligo General Hospital, despite the brief being signed off several years ago. It appears that, subsequent to this agreement, attempts were made locally unilaterally to enlarge and extend the proposed structure, with consequent delay at a time when funding has become more precarious.

In Donegal, an attempt was made to requisition the acute unit at Letterkenny General Hospital for medical step-down beds and to return the acute admission activity to the old St Conal's, where just three continuing care wards with many elderly patients remained. The promise was that, in return for this compliance, a new purpose-built unit would be constructed on a green field site on the general hospital campus. The difficulty with this proposition was that there were insufficient funds to accomplish it. In the event, nothing happened and the current unit at Letterkenny remained unsatisfactory in many respects, particularly because of overcrowding. It seems to the Inspectorate that the most feasible solution was to remodel and extend the existing structure on a phased basis, working with a reduced bed complement, supplemented by a more community-based outreach method of care delivery, including more effective use of the new and extensive day hospital at

Letterkenny for more acutely-ill patients. Encouragingly, the service took possession of further community residences in 2002 which had the potential to close the remaining wards in St Conal's, allowing it to close for psychiatric purposes.

SOUTH-EASTERN HEALTH BOARD

Here, there were five services soon to be contracted to four, with the amalgamation of those of Kilkenny and Carlow. This will be effected through the closure of both St Dymphna's, Carlow and St Canice's, Kilkenny to admissions, those for both counties going henceforth to the new combined unit at St Luke's General, Kilkenny which should have opened during 2002. Thereafter, the residual components of both original hospitals should be accommodated in community settings, allowing both to close as psychiatric hospitals. Further community initiatives will be required for the new combined service such as, for example, a day hospital in Kilkenny City and specialised services for the elderly and for rehabilitation. Already enlarged accommodation for the elderly in St Canice's had become available through the transfer from the hospital to new improved facilities at Kilcreene of all intellectually disabled persons. The St Canice's component catering for the elderly should now be de-designated and integrated with the generic services for older persons.

In Wexford, matters were at a standstill during the year, partly as a consequence of difficulties at senior management level, which impaired progress. This was all the more troublesome as this service badly needs moving forward, particularly in respect of its completely inadequate acute admission facilities.

At Waterford, increased day provision was required to allow community-based activities to progress. It was hoped to acquire a large house in the St Otteran's campus to replace the locked ward in St Otteran's and to set up a rehabilitation service. Thereafter, a de-designated St Otteran's would provide care for the elderly through the integration of this service with generic elderly services and with the recently-established specialised service for later life psychiatry in this catchment area.

There were a number of problems in the Tipperary service. Plans were afoot to designate a new and separate service for Tipperary North Riding, centred on a new psychiatric unit at Nenagh General Hospital when funds allow. Because of the limited population base of approximately 60,000, it will be difficult to establish a comprehensive multi-specialty service in this setting. It is a disappointment that the Cashel initiative, which was to have a number of psychiatric components, had not materialised up to the end of 2002. Meanwhile, the intellectually disabled in St Luke's Hospital, Clonmel were in need of a specialised service not currently available to them and were misplaced in this psychiatric hospital, sharing accommodation, as they often were, with mentally ill persons. The acute admission unit for this service, St Michael's on the Clonmel General Hospital campus, needed extensive refurbishment, re-modelling or replacement. In addition, there were limited community services, particularly in Clonmel itself.

SOUTHERN HEALTH BOARD

At Cork, a milestone was reached with the closure of last remaining fragment of Our Lady's Hospital, St Kevin's, and the transfer of the remaining patients to the refurbished St Anne's Unit at Shanakiel, vacated when the acute admission unit for the North Lee service transferred to the Mercy hospital. The St Anne's Unit, re-named Caraig Mór, needed rationalisation, both in regard to clinical administration and function, as pointed out in the relevant section of this report.

The North Lee service had extended its community base with some new structures and functions and the acute in-patient unit at the Mercy Hospital was functioning well.

The service at South Lee had finally sectorised and was at the point of planning a more rational delivery of services, including augmenting its very limited community facilities. The acute unit at Cork University Hospital needed considerable change to bring it up to modern standards of acute care.

The North Cork service was largely an institutionally-based activity working out of, but mostly within, St Stephen's Hospital, Glanmire, although a new high-support community residence at Mallow was something of a showcase and plans were in train to provide alternative and better day care at Kanturk. However, much further work needed to be done, including limiting admission rights to St Stephen's to its catchment area. The Cork services needed to provide specialised services for the elderly and for rehabilitation, either on a shared basis or individually. It was essential that this service transfer its acute admission unit to Mallow General Hospital but the Inspectorate was disappointed that this matter was not being regarded as a priority.

West Cork was designated a mental hospital district during the year so that all patients from the catchment area would be admitted there rather than being brought directly to Cork city. However, to cater adequately for this enhanced role, an area of close observation needed to be created in the unit at Bantry Hospital, the acute in-patient base. Plans to enhance the community services in this catchment area were progressing and a new purpose-converted house at Bantry was ready for occupation. It was felt important that progress should be made in making permanent consultant appointments to this service.

In Kerry, progress continued to be made. During the year, the acute unit at Tralee was designated a district mental hospital, thus ending the practice of Gardaí bringing PUM patients to St Finan's Hospital, Killarney. The new day hospital at Tralee opened, replacing the former Caherina premises, which should have a future as a day centre. Other additions included the newly-built community residence at Listowel and a day centre at Castleisland. Further community changes and developments were being planned. However, much of the existing accommodation in St Finan's was unacceptable and emphasised cogently the need for rehabilitation services for the elderly and for those physically disabled, away from St Finan's which should soon close as a psychiatric facility — a view shared by management who had been working on proposals for alternate usage for the building and campus.

WESTERN HEALTH BOARD

The West Galway service, covering Galway City and that part of the county further west, required improved physical facilities. The acute in-patient unit at University College Hospital needed considerable upgrading. Even at the most fundamental level of maintenance, there was much to be done — the unit looked shabby and unkempt, lacking fresh paint and with leaking doors and windows. Some relatively minor structural changes within to improve patient comfort and observation scheduled to take place during the year, did not occur. Likewise, the acquisition of new day premises in Galway City to replace the unsatisfactory Halla Padraig did not eventuate. Unit 8 in Merlin Park Hospital continued to function, both as a high-support residence and as an overflow facility for the acute unit. As far as the latter role is concerned, the Inspectorate has considerable anxieties about the transfer of patients from the acute unit to Unit 8, often late in the day, unaccompanied by a staff member and without adequate clinical documentation. The provision of a number of extra beds in the acute unit as intended, but so far unaccomplished, together with more community outreach practice should do away with this highly undesirable practice. The original purpose of Unit 8, and the reason it was established and funded, was to serve a rehabilitation function, particularly for West Galway long-stay patients in St Brigid's Hospital, Ballinasloe. Unfortunately, this objective was never really fulfilled and the current situation was that most of the residents could quite easily transfer to community living were there such places for them; sadly there were not, pointing up once again one of the most urgent problems facing the mental health services — housing. However, Unit 8 should cease taking overflow patients, be de-designated and link up with the newly-established rehabilitation service in East Galway. Finally, the practice of transferring patients from the catchment area and the acute unit to St Brigid's, Ballinasloe, although much reduced in recent years, should stop altogether. To enable this to take place, some strengthening of the West Galway psychiatric teams, to allow for outreach and domiciliary work, will be required.

Matters at St Brigid's Hospital, Ballinasloe continue to be quite unsatisfactory, and, in some respects, conditions were unacceptable. While accommodation for older persons, who make up about fifty per cent of the resident population, mainly in the New Building, were reasonable having been upgraded in recent times, the same is not true of the original hospital. A particular instance was Ward 1, a museum piece from another, unenlightened age, which denigrated our psychiatric services and which should have no place in modern practice. The Inspectorate formed the view that senior local management were well aware of the shortcomings and were doing everything they could to improve matters but were frustrated by opposition from staff representative bodies. So concerned was the Inspectorate about the unchanged conditions in St Brigid's that the unusual step was taken of making an interim report, with the effect that the Chief Executive Officer set up a partnership group, under independent chairpersonship, in an attempt to remedy matters. While admission wards in St Brigid's had been substantially improved in the past couple of years, they were still basically unsatisfactory. The Inspectorate remained committed to the view that the appropriate resolution of this problem was the provision of an acute admission unit at Portiuncula Hospital. Not alone will this improve matters from the admission point of view, but its symbolic value in demonstrating a break with the old mental hospital and the psychiatry of the past should have significant psychological, attitudinal and cultural

impact in a situation where this is badly needed. On the positive side, there had been some ward closures and amalgamations in the old hospital. A new day hospital opened in Ballinasloe and a specialised rehabilitation team had commenced operation.

There was less to report at Roscommon. Two new premises had been acquired in the town, the first to accommodate a day hospital to replace the tiny current operation in the acute unit in Roscommon Hospital and the second to serve as a possible sector headquarters. Efforts were in train to find a suitable house for community residence purposes. A similar quest was being pursued in Athlone to find more suitable day care accommodation.

The new acute admission unit at Castlebar General Hospital in the Mayo service had been ready for occupation by year's end but, once again, progress had been halted by the usual staff negotiations which have become such an irritating feature of such transitions. Nonetheless, the aspiration was that all would be settled early in 2003. On completion of the admission move from St Theresa's at St Mary's Hospital, Castlebar this unit would become a rehabilitation unit cared for by a multi-disciplinary rehabilitation team. There would then remain in St Mary's only the long-stay elderly whose accommodation had been much improved in the past two years. The hospital should then be de-designated and care of the elderly become part of the generic services for this age group in the county in association with the specialised psychiatric service for later life operating out of the Sacred Heart Home in Castlebar. The de-occupation of St Mary's had been expedited by the recent transfer of intellectually disabled persons to specialised and improved residential units at St Attracta's in Swinford. On the community side, there had been the provision of a modern and extensive purpose-built community residence in Castlebar with a new adjoining workshop and training premises to operate in conjunction with the rehabilitation service. This, together with the newly-acquired day facility at Westport, was a positive augury for the future of this service.

THE CENTRAL MENTAL HOSPITAL DUNDRUM

This hospital is managed by the East Coast Area Health Board but serves a national function. It has been criticised in Inspector's report after report because of the poor quality of its accommodation and for other reasons set out in the detailed report specific to it. The main building dates from 1845 and, apart from periodic re-decoration, remains unchanged since then. It is, therefore, totally unsuited for current usage, both on accommodation and humanitarian grounds. To give some oft-repeated instances once again, it is only necessary to decry the wholly unsatisfactory conditions in which patients are secluded in the hospital, particularly in Ward 1, and the fact that, because sleeping rooms did not have en-suite sanitation and were locked during the night, the degrading practice of "slopping out" each morning continued. These views of the Inspectorate were reinforced by the report to the Irish Government of the CPT. In 2001, the East Coast Area Health Board set up a Working Party to advise on the future of the CMH. This report recommended the retention of the existing building but with fundamental and radical re-modelling at considerable cost. The parent ERHA subsequently adopted this report.

At the same time, proposals for the more effective use of the hospital, particularly in the context of general and CPT concern about prisoners perceived to be mentally ill being kept in padded cells in the prisons, were being formulated by a group tasked with evolving a service-level agreement between the Departments of Health and Children and of Justice, Equality and Law Reform. The commitment to strengthening the forensic services was exemplified by the extension of existing consultant teams to five in the Eastern region and with greater remit and to establishing the specialism in Cork and Limerick.

PRIVATE HOSPITALS

The two large Dublin-based private hospitals, St Patrick's and St John of God's, have continued to upgrade their accommodation and both have now, *inter alia*, opened new high-quality admission wards, mostly in the current year. These improvements have put in place state-of-the-art facilities for newly-admitted patients in terms of accommodation and treatment. Both have created specialist approaches to various sub-types of psychiatric disorder. Equally, both, being national services, face the problem of catering for the rehabilitation needs of persons with the disabilities of enduring illness in a comprehensive manner. The smaller private hospitals, some of which suffer from somewhat cramped premises, were planning improved accommodation. For instance, Bloomfield is moving to a new location where a purpose-built building will be put in place and the Kylemore Clinic will shortly re-build on the existing site.

CHAPTER TWO

Eastern Regional Health Authority

EAST COAST AREA HEALTH BOARD

CLUAIN MHUIRE MENTAL HEALTH SERVICES — 2002 INSPECTION

INSPECTED ON 5 DECEMBER, 2002

GENERAL DESCRIPTION OF THE SERVICE

The Cluain Mhuire community mental health service was established in 1971 to serve south-east Dublin, including Dun Laoghaire. The population of the catchment area was 170,000. The St John of God Order administered the service under an agreement with the Eastern Regional Health Authority. The inspection report for this service should be read in conjunction with that of St John of God Hospital, Stillorgan.

IN-PATIENT CARE

In-Patient care was provided at St John of God Hospital, Stillorgan, which had forty-two beds contracted as public beds in five integrated wards. This component of the Cluain Mhuire service was described in the report on that hospital.

Age and Length of Stay of all Patients at 31.12.01

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	3	14	9	—	1	27	79.4
3-12 Months	—	—	1	4	—	—	5	14.7
1-5 Years	—	—	—	1	1	—	2	5.9
> 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	3	15	14	1	1	34	100
% of Total	—	8.9	44.1	41.2	2.9	2.9	100	

Status of public patients on the date of inspection 2002

Status	Male	Female	Total
Voluntary	13	17	30
Temporary	8	3	11
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	21	20	41

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
417	2.45	N.A.		86.1	13.9	413	2

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	35	518
Day Centres	3	303	353
Out-patient clinics	2	N.A.*	5,261

*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
3	15	1	15	1	20

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
13	15.6	28	15.23	10.6

COST

The cost of the Cluain Mhuire Mental Health Service was €8.3 million in 2001.

GENERAL COMMENTS

The Cluain Mhuire service was the adult mental health service with a catchment area, which included all of Community Care Area 1 and part of Community Care Area 2 serving a population of 170,000. In-Patient and community services were provided for the Dundrum/Ballinteer sector of catchment Area 2 since the service was founded in the 1970s. Service was provided on a contract basis by the St John of God Order and was funded exclusively by the Eastern Regional Health Authority, though having ultimate administrative links with the overall St John of God Order and with St John of God Hospital in Stillorgan. The service maintained administrative independence in day-to-day activities. The service purchased in-patient beds to a maximum of forty-two from the nearby St John of God Hospital at a rate of €214 per bed per day. This was a nine per cent discount on the ordinary rate. The service regarded itself as a centralised non-sectored service. The catchment area headquarters were located at Cluain Mhuire in Newtownpark Avenue. It formed the centre of out-patient activity. The day hospital for the catchment area was situated in St John of God Hospital. It was rather cramped, although

it had been extended somewhat over the past year or so. Nevertheless, the service, and the Inspectorate, would like to see the day hospital located elsewhere within a community setting. There were tentative plans to relocate this day hospital to lands adjoining the Cluain Mhuire building. Services for the elderly and the department of later life psychiatry were provided by a team serving Area 1 and 2, with acute in-patient assessment beds at the St Camillus Unit of St Vincent's Hospital, Elm Park. Separate provision had been made for acute assessment beds in the new psychiatric unit scheduled to open at St Vincent's Hospital in 2003. In addition, a day hospital, Carew House, located on the campus of St Vincent's Hospital provided day hospital facilities for the elderly from both Area 1 and Area 2 catchment services. The consultant-led team of later life psychiatry had admission rights to the elderly care wards of St John of God Hospital and to the continuing care facilities at Tivoli Road in Dun Laoghaire.

A new liaison consultant assessment service had been established since the last visit of inspection. This provided assessment and treatment at St Michael's Hospital, Dun Laoghaire and at St Colmcille's Hospital in Loughlinstown. The consultant psychiatrist attached to Newcastle Hospital looked after patients from County Wicklow at St Colmcille's.

The Inspectorate visited the community residences, Oropesa, Crannóg and Avila last year, and found them to be of high quality in terms of accommodation and skill-mix staffing which matched provision to need, unlike the over-provision so common in many health board community residences. As mentioned in previous reports, the Inspectorate was impressed with the rehabilitative ethos that pervaded the multi-disciplinary teams. The intensive programmes operating in Burton Hall were impressive. There were three complaints and twenty requests under the Freedom of Information Act made to the local complaints appeals manager during the year. All appeared to have been dealt with satisfactorily. There were seven accidents to patients and two assaults on patients in the community service during the year. Both assaults were self-inflicted injuries.

RECOMMENDATIONS

It is recommended that a new community-based day hospital be acquired for this service.

PSYCHIATRIC UNIT, VERGEMOUNT CLINIC — 2002 INSPECTION

INSPECTED ON 3 DECEMBER, 2002

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 addition, the service management team administered the specialist Alcohol/Addiction service at Baggot Street Hospital and the Elderly Care Unit at Tivoli Road, Dun Laoghaire.

IN-PATIENT CARE

In-Patient care was provided at Vergemount Clinic where twenty-nine beds were provided in one male and one female unit. In addition, there were two de-designated Elderly Care Units on the campus of Clonskeagh Hospital administered and staffed by the mental health service.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	—	5	—	3	—	8	42
3 to 12 Months	—	2	—	7	—	—	9	47
1 to 5 Years	—	—	—	2	—	—	2	11
Over 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	2	5	9	3	—	19	100
% of Total	—	11	26	47	16	—	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	7	—	5	6	—
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
1	—	—	—	—	19

Status of In-Patients on the date of inspection 2002

Status	Male	Female	Total
Voluntary	6	10	16
Temporary	—	—	4
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	10	10	20

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
346	3.5	52	15.0	93.4	6.6	336	0

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of Persons Attending
Day Hospitals	1	45	1,069
Day Centres	1	28	42
Out-patient clinics	2	310*	Not provided

*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	7	1	14	1	14

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
15	9.5	81	59.75	10

COST

The cost of the Area 2 Mental Health Service was €9.9 million in 2001.

GENERAL COMMENTS

The most engaging consideration in this service was the opening of the new fifty-four bed acute unit which was near completion, with the handing over scheduled for February or March, 2003. This unit in St Vincent’s Hospital, Elm Park was to replace the existing admission facilities at Vergemount Clinic. The second priority was the opening of the recently acquired large bed and breakfast premises on Morehampton Road to provide

high-support residential care for fourteen patients. Negotiations had begun on the complicated and protracted discussions to effect the transfer of patient care from Vergemount Clinic to the new acute psychiatric unit. The Inspectorate was most anxious that these discussions should proceed with all alacrity, given the very unsatisfactory nature of the acute in-patient provision currently available to this service at Vergemount and, to a lesser extent, at St Vincent's Hospital, Elm Park. On the second initiative, Morehampton Road, some work on minor structural alterations needed to be done in order to ensure compliance with fire regulations.

Vergemount or Area 2 services comprised a catchment area with, apart from some small pockets, a relatively privileged socio-economic population and made a less than average demand on the public service. This in part accounted for a relatively low admission rate in the national context, with re-admissions making up eighty-five per cent of all admissions. The catchment area was divided into three sectors, one of which overlapped into the adjoining Area 1 catchment area and, in addition, provided specialised psychiatric services for the elderly on a joint basis with Area 1. This elderly service had six assessment beds in the new fifty-four-bedded unit virtually completely constructed at St Vincent's. This service also had a day hospital on the St Vincent's, Elm Park campus and, in addition, continuing care beds in Units D and E on the Vergemount campus and at Tivoli Road in Dun Laoghaire and, possibly, at St John of God Hospital, Stillorgan. It should be pointed out that, in addition to this, St John of God, Stillorgan also provided two beds on a contract basis for the general adult service of the catchment area for involuntary patients. In addition to its services for the elderly, Units D and E at Vergemount also catered for sixteen long-stay patients from the catchment area. These patients were obviously in need of rehabilitation and, in this context, it was noted that a specialised rehabilitation team, consultant-led, was envisaged for this service. In the light of the acquisition of fourteen extra high-support community residential places at Morehampton Road, all long-stay patients, including the four blocking acute beds in Vergemount Clinic currently, had been the subject of assessment in relation to their perceived needs. Some re-organisation and re-allocation of patients between the various levels of support structures in the service needed to be undertaken.

There was a dearth of community-based facilities in this service. There were no acute day hospitals (the Glenmalure day hospital did not in our opinion meet the criteria for being an acute day hospital) and there was no sector headquarters. There was a substantial amount of work to be done to remedy these defects. In addition to the three full-time adult consultant psychiatrists in the service, and the consultant of later life psychiatry who also serviced the adjoining Area 1, there was a further consultant who worked half-time with the Vergemount adult service. His other responsibility was with perinatal psychiatry at the National Maternity Hospital, Holles Street. A further psychiatrist, appeared to have spasmodic responsibility in the service on a "covering" basis but his main activity was concerned with alcohol services in Baggot Street Hospital and Stanhope Street. There were two occupational therapists, two social workers but no psychology service, although psychology could be accessed on an irregular basis from a central pool of psychologists external to the service.

Plans to provide a sector headquarters, either in Baggot Street or at the Glenmalure premises, had not materialised.

Medical case notes needed attention, both in relation to their design and content. There were obvious shortcomings, such as difficulty in ascertaining basic details, including legal status, from the present top sheet. In addition, the layout of the records needed considerable attention. Medical case note-taking itself was less than impressive in areas such as detailing the paths to admission, why admission was deemed necessary, why alternatives to admission were not considered or, if so, why they were thought to be inappropriate and with whom the matter was discussed before a decision was made. Detailed intake assessment procedures were not always documented and there was, by and large, an absence of a planned programme approach for the patient, nor any indication that he or she had themselves been involved in joint planning for their treatment and objectives.

The Ringsend day centre, which was visited and described in the 2001 report continued to operate satisfactorily. The new premises at Morehamptom Road purchased at a cost of €2.5 million was expected to accommodate fourteen residents, six of whom were residing in the acute unit at Vergemount at the time of inspection.

There were twenty-three, seven male and sixteen female, involuntary admissions to the Vergemount unit last year and no extensions of involuntary admission. Three of the patients admitted as voluntary patients were re-graded to involuntary status during the course of their hospitalisation. There were no deaths in this service in 2001. Twenty-three patients took their own discharge from the service against medical advice in 2001 and follow-up procedures were in place if deemed clinically appropriate. Nine patients were transferred from the Vergemount unit to St Brendan's and a further patient transferred to St John of God Hospital during 2001.

There were no research projects undertaken in this service governed by the Clinical Trials Act, 1987-1990. There were no complaints made to the local complaints appeals manager during the year. However, three requests under the Freedom of Information Act were made and all appeared to have been dealt with satisfactorily. Management should closely monitor the handling and outcome of all informal complaints, both to ensure minimum delay and note any quality implications arising from the complaint. All patients, irrespective of their status, must be informed of their statutory legal rights. Voluntary patients should be told if they wished to leave hospital, they must discuss this with their consultant or, in his or her absence, the clinical nurse manager. Whilst the rights of detained patients were prominently displayed in the in-patient care areas, they should also be included in the hospital brochure and a system should be in place of ensuring that this information was brought to the patient's attention. Informing patients of their rights contained two tasks, the first was to provide an explanation via the hospital brochure and the second was to be satisfied that the patient understands his or her rights. Upon admission or as soon as practicable thereafter, the patient should be informed of their rights. Ideally, this information should be given in writing by handing the appropriate patients' rights leaflet to the patient with a verbal explanation of the contents. An entry should be made in the patient's nursing process documentation that an oral and written explanation had been

given with an indication of the patient's comprehension. If the patient was clearly incapable of understanding, this should be recorded and the information should be repeated at regular intervals using professional judgement on deciding the patient's capacity for understanding.

Thirty-six patients were placed on one nurse to one patient, special nursing supervision and there were 388 spans of special supervision last year. This year (2002), up to the date of inspection, forty-eight patients were placed on special nursing supervision and there were 538 spans of special supervision involving duty hours of twelve or more hours. Within the unit, special nursing supervision was initiated and discontinued on the instructions of the patient's consultant psychiatrist. Special nursing occurred because of assessed significant risk of self-harm or harm to others. The high level of special nursing supervision being undertaken required review. Several risk factors arose from the present situation and these were: the absence of specific levels of observation and criteria made it impossible to determine, through audit, the reliability of the observation undertaken and the efficacy of special nursing supervision. The duration which one nurse observed a patient also required review. The whole policy and procedure relating to special nursing supervision required review by all members of the multi-disciplinary team. A system of prescribed recorded observation, that was higher observation than the normal ward observation, should be introduced so that a clinician making decisions in relation to patients that was appropriate and responsive to their needs had a range of options available to him/her.

The written policy for the ordering, prescribing, storing and administration of all medicines was reviewed and updated in 2001. The policy and procedure document was comprehensive. Most prescriptions examined were easy to read. All were dated and signed individually. All of this resulted in a low risk of error of administration. Discontinued drugs were signed off using the discontinuation columns and all prescription cards examined were kept up to date. The drug administration recording card should have provision for the nurse's signature in full when next re-printed. The section for recording adverse drug reactions and known sensitivities had not always been completed in cards examined. Even if the patient has no known drug reactions or sensitivities, this fact should be recorded in the space provided. Since the last visit of inspection, the service had produced a written information leaflet for patients on prescribed medication. This was available in the unit for patients' information and reference.

Twenty-one patients were prescribed electro-convulsive therapy at the Clonskeagh unit last year. The arrangements for ECT were all satisfactory. The unit had a dedicated ECT suite comprising three or more rooms, including a separate waiting room and recovery area. A policy for ECT had been reviewed and updated and a named consultant psychiatrist had responsibility for the ECT clinic. Whilst there was an appropriate induction process for all new doctors on electro-convulsive treatment, records should be kept of the names of the persons inducted and a brief outline of the induction process. There were 186 accidents to patients in the service last year and ninety-nine resulted in minor injury such as scratch or bruising. There were no serious injuries. There were five accidents to staff resulting in minor injuries. There were eleven assaults on patients by other patients,

two assaults resulted in minor injury. Of the sixteen assaults on staff by patients, fifteen resulted in minor injury.

There was a high turnover of nursing personnel in this service. Recruitment from overseas had helped alleviate the acute staffing difficulties of the previous two years. However, this had not brought the nursing numbers up to the required establishment complement. There were four established occupational therapy posts in the service but only two were filled at the time of inspection. Similarly, only two social workers were employed and no psychologist was employed in any of the three teams, although they had access to a psychology service provided centrally. It was also noted that there was no permanently appointed consultant psychiatrist in the service. These matters required attention. Since the last inspection, a new clinical nurse manager III and community mental health nurse had been appointed.

The management team of this service met on a six-weekly basis and appropriate minutes of meetings were recorded. There was a fire and safety committee for the hospital as a whole. Safety statements were in place and there was a detailed fire manual with records of fire awareness training for staff. The system of reporting and documenting incidents and accidents was satisfactory.

All staff appeared to be aware of the importance of approved policies, procedures and protocols. At the time of inspection, seventeen policies and procedures had been reviewed and updated and revised draft policy and procedure statements had a note on date developed and date approved. The policy procedures and protocols should not refer to patients as “clients”. They are patients as defined under the Mental Treatment Act, 1945 as amended. It was noted that all of these policies and procedures would require further review and updating in the context of the re-location of acute services to St Vincent’s Hospital in Elm Park. Work should commence between St Vincent’s and the Area 2 management team to ensure policies and procedures were in place at the time of opening or as soon as possible thereafter. A system should also be put in place to ensure revised and updated policies were formally introduced to relevant staff, ensuring an awareness and understanding of content. Staff should sign that they had read, understood and intended to comply with the policy and procedure content. Guidance on the management of illicit drug use or drug-related incidents should be included in the policy manual. This service should have a policy indicating when patients went absent without official leave, setting out the responsibility for returning the patient. The policy should clearly state who was to take charge of the procedure, how any local search was to be organised, when and who should contact the Gardaí and when and who should contact the patient’s relatives. All of this should be done in the context of the new arrangements with St Vincent’s University Hospital.

The ‘Roper Model’ of nursing was the nurse care planning system in operation. Nurse care plans examined were all completed satisfactorily. All entries were made as soon as possible after the events to which they related. All were accurately dated and some entries also recorded the time of entry. The time of entry should be recorded in all nursing notes using the 24-hour clock. Writing “nocte” on night reports was not satisfactory. As a number of abbreviations were noted on the records examined, a written policy on the use of approved abbreviations should be introduced. Records examined had entries relating to

how well patients settled into the ward on their first day of hospitalisation. The name of the patient's primary nurse should be clearly recorded in the nursing records. Ideally, the nursing record should reflect the involvement of patients in planning and making choices and decisions about their own care and treatment and similarly the nursing evaluations should include patients' views about progress.

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. Whilst there was provision for the recording of the patient's name on each continuation page, this was not always done. Written instructions on filing of documentation within the record was required. Record folders had an open pocket on the inside rear cover and some contained copious amounts of clinical material. Risks associated with loose material included delay in accessing pertinent information and misfiled information.

Two female voluntary patients were interviewed to assess their opinion of services provided. Both patients were very positive in their assessment of the services. Both were well-acquainted with their consultant psychiatrist and nursing staff and were pleased with the amount of contact they had with them whilst hospitalised. Both patients were aware of the nature of their illness and were fully informed of their prescribed medications and side effects the latter could cause. One patient was not allowed wear personalised clothing post-admission, but the reason for this was fully explained and the patient accepted and was happy with the explanations given. Patients were aware that there was an information booklet on hospital services on the information notice board. Neither of the patients had read the booklet and staff had not made them aware of its contents. Patients were not aware of their rights under the Mental Treatment Act, 1945 or of the procedure involved should they wish to register a complaint. Patients found the quality of food provided excellent and they were also pleased with the overall ambience of the unit in relation to décor, hygiene, toilet facilities, etc. All reported that staff respected their dignity and privacy and one patient expressed a fear that the services in the new unit at St Vincent's University Hospital might not be up to the standard provided at Vergemount Clinic. One patient had seen the psychiatric social worker during the course of her hospitalisation and was provided with sufficient information relating to social welfare and other benefits. The patient was satisfied with the services provided by the social worker. The patient interviewed had not been referred to the psychology service.

There were 394 first referrals and 647 return referrals to the Department of Later Life Psychiatry which had four functional illness beds at St Vincent's University Hospital and access to beds at St John of God Hospital as required. A new day hospital at Carew House on the campus of St Vincent's University Hospital opened during the year. There were no day centres for this service. The service had access to sixty-eight long-stay beds, twenty each at De Brun and Whitethorn House on the campus of Clonskeagh Hospital and a further twenty-eight at Cois Ceim Hostel, Tivoli Road, Dun Laoghaire. All of these facilities were visited. All were clean and maintained to an acceptable standard and the care provided for patients was satisfactory. De Brun and Whitethorn House had thirty-two beds each but only twenty were occupied in each house at the time of our visit. Whilst both units were staffed for one hundred per cent occupancy rate, they were operating at a sixty-four per cent occupancy rate and this required review.

RECOMMENDATIONS

It is recommended that:—

- 1. All the necessary negotiations and arrangements for the transfer of acute services from Vergement Clinic to St Vincent’s University Hospital, Elm Park be progressed so that there are no delays moving from one location to the other as soon as the new unit is ready for occupation.
- 2. Consideration be given to setting up community mental health centres and day hospitals in Glenmalure, Milltown (where the existing day hospital needs to be physically enlarged and the range of patients with which it copes enhanced) and at Baggot Street Hospital.
- 3. Day activity centres should be provided at strategic locations within this catchment area.
- 4. The high-support community residence at Morehampton Road should be opened as soon as refurbishment is completed.
- 5. A review of the bed occupancy of the two thirty-two bed continuing care units for the Department of Later Life psychiatry be undertaken.

CENTRAL MENTAL HOSPITAL — FIRST 2002 INSPECTION

INSPECTED ON 20 MARCH, 2002

GENERAL DESCRIPTION OF THE SERVICE

The Central Mental Hospital (CMH) provided a forensic psychiatric service for the entire country — a population of approximately 3.6 million.

IN-PATIENT CARE

In-Patient care was provided at the eighty-eight-bed Central Mental Hospital, Dundrum, in one female and six male units.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	1	17	1	1	—	20	
3 to 12 Months	—	1	11	1	—	—	13	
1 to 5 Years	—	—	16	3	1	—	20	
Over 5 Years	—	—	7	19	3	1	30	—
All Lengths of Stay	—	2	51	24	5	1	83	
% of Total							100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	42	16	8	2	—
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
5	2	—	8	—	83

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
136	N.A.	N.A.	N.A.	0	100	120	2

Legal Status of all Admissions in 2001

Status	Total
Guilty but Insane	1
Remand	80
Sentenced	49
Unfit to Plead	—
Section 207	—
Section 208	6
Total	136

Legal Status of In-Patients on the Date of First Inspection 2002

Status	Male	Female	Total
Guilty but Insane	18	—	18
Remand	20	3	23
Sentenced	14	2	16
Unfit to Plead	5	—	5
Section 207	7	—	7
Section 208	12	2	14
Total	76	7	83

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
11	11.5	110	15.25	1.75

COST

The cost of the Central Mental Hospital service was €10 million in 2001.

GENERAL COMMENTS

The Central Mental Hospital was the only forensic, secure hospital in Ireland. It was established under the provisions of the Central Criminal Lunatic Asylum (Ireland) Act, 1845. The hospital provides psychiatric care in conditions of medium and high security for patients transferred from the prison system, those found unfit to plead or guilty but insane, and those transferred from local area mental health services under Section 207 or Section 208 of the Mental Treatment Act, 1945. Approximately 1.3 per cent of all committals to prisons are transferred to the CMH, as compared to 0.2 per cent in the UK and 0.8 per cent in Holland. The CMH provides forensic psychiatric assessment, treatment and rehabilitation for all the health boards in the country and, in addition, provides the Irish prison population with an assessment and treatment service in the greater Dublin region. The hospital was managed directly by the Department of Health up to 1972, and from 1972 by the Eastern Health Board. With the re-arrangement of the health services in the eastern region, responsibility for its management transferred to the East Coast Area Health Board.

In the Inspectorate reports of April and December 2001, and in previous reports, it was reported that little had changed in the physical structure of the CMH. Those reports commented that the main building was quite forbidding in parts 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 reports also highlighted the unacceptable standard of the seclusion rooms in Unit 4 and Unit 1 and the need to have these matters attended to as a matter of urgency. It gives the Inspectorate no pleasure to report that, at the time of the present inspection, nothing had changed at the CMH — if anything, conditions had deteriorated even further. The overall physical conditions at Unit 5, Unit 1 and, to a lesser extent, at Unit 4, were unacceptable and, as reported previously, quite unsatisfactory for the current purpose of those units. Conditions in some parts of Unit 5 and Unit 1 were most unsatisfactory. Previous reports have highlighted that the archaic seclusion accommodation in Unit 1 was unfit for a mental health institution of the twenty-first century. These archaic conditions still prevailed at the time of this inspection and no attempts had been made to redecorate these areas in order to bring some little acceptability to them, pending relocation of patients. All patients in the old building of the CMH were locked into rooms at night and had to slop out in the morning, as there was no in-room sanitation. The physical conditions, particularly at Unit 1 and Unit 5 and, to a lesser extent, at Unit 4, were without doubt almost the worst in the country. Concerted management action was required to ensure that patients are relocated from these facilities as a matter of urgency. The newer units, built in the 1980s, initially for the assessment of young offenders, had become home for many long-stay patients. While offering a better standard of accommodation than the old building, some redecoration and refurbishment was required. The units themselves had low ceilings and appeared crowded. The Inspectorate welcomed the provision of external doors to enable easier access to courtyards for patients residing in these units.

On the positive side, the management and the health board had invested funds to upgrade Unit 2 and Unit 3, with a view to relocating patients from Unit 5 and from one unit in the new building, and the transfer of female patients from Unit 4 to the new building. It was

most disappointing that some of these changes had not occurred as these vacant and upgraded areas were practically ready for occupation at the time of the last year's inspection of the CMH. The Inspectorate was informed that these changes would occur shortly after this inspection. While the redecoration and refurbishment of Unit 2 and Unit 3 and the forthcoming relocation of patients from very unsatisfactory facilities to these upgraded units was welcomed, this could only be seen as a short-term, interim measure as the overall design of the units remained unchanged and in-room sanitation was not provided.

To address the medium to long-term needs of the national forensic service, the East Coast Area Health Board established a working group in 2001 to review service provision and make recommendations for the development of the CMH and associated services. This group had completed its deliberations and had reported to the ECAHB. The group recommended substantial redevelopment of the hospital site, providing high-, medium- and low-security zones, improved access security, car parking and community residential facilities. There were substantial costs associated with the proposed development and, at the time of inspection, it remained unclear as to when this redevelopment work would commence. It is absolutely essential that any necessary option appraisal work be carried out as a matter of urgency, with a view to setting an agreed time frame for the redevelopment of this service and ensuring that patients are cared for in acceptable physical surroundings appropriate to their needs.

The Inspectorate very much welcomed the appointment of additional consultant forensic psychiatrists to the CMH, and the commitment on the part of the ECAHB to strengthen the five multi-disciplinary teams now working within this service. Attempts were under way to recruit occupational therapists, community mental health nurses, additional psychologists and social workers.

At the time of inspection, fourteen patients were hospitalised under Section 208 of the Mental Treatment Act, 1945. One patient came from Cork and the remainder came from Dublin, seven having been transferred from St Brendan's Hospital. Following the Inspectorate's comments of last year, the guidelines on the transfer of patients under Section 208, as published in the annual Inspector's Reports, were followed. There was a need within the service to appoint a designated person to ensure appropriate co-ordination of medical files and scrutiny of all detention forms, with appropriate checks and balances to ensure that patients were informed of their legal rights. Also required was an appropriate administrative structure to ensure that each referring service was appraised of the necessity for medical assessment prior to any decision to extend a patient's detention period. There appeared to be some problems of communication between the referring hospital and the CMH in relation to legal forms. To address this problem, a system of tracking legal documentation should be put in place. There was also a need to review Section 208 patients on a monthly basis. This should be a joint assessment between the CMH and the referring hospital, particularly as some Section 208 patients had been in the CMH for unduly lengthy periods of time.

Eight patients were detained under Section 207 of the Mental Treatment Act, 1945 and all had become long-stay patients. Three had been admitted in the 1960s, two in the 1970s,

two in the 1980s and the most recent in 1992. Efforts should be made to rehabilitate these patients and return them to their referring service.

Forty-seven of the patients in the CMH were long-stay, which left limited bed space for admissions. This was contributing to the difficulties experienced by some services in having patients transferred. Ten of the patients had an intellectual disability; in the opinion of the Inspectorate, these patients needed specialised care in services appropriate to their needs.

There was a written policy for the ordering, prescribing, storing and administering of medicines, which was dated October 1999, but this policy was not available in every ward. The policy itself required review and updating and should be available for staff information and reference in each clinical location. The standard of prescription writing within the service was variable. Some prescriptions had a low risk factor of drug error as they were written in block letters and those that were scripted were not difficult to read. However, a number of prescriptions had a moderate risk factor associated with error; these were scripted and were difficult to read. There was also an increased risk factor of drug error in prescription cards where discontinued prescriptions were greater in number than current prescriptions. This was noted particularly in Unit B. All prescriptions should contain the signature in full of the prescriber. Some signatures on cards examined were illegible and staff were not able to identify the prescriber. The discontinuation column was not always completed. The transport system between the pharmacy and the wards was not adequate. Medical preparations in transit should be in locked containers. The drug administration recording card had provision for the nurse's signature in full. The standard here was also quite variable. Some signatures were illegible. There was an emergency trolley at an appropriate location for use within the entire hospital. This tray was checked regularly to ensure that resuscitation equipment was in working order and that listed medical preparations were in date.

The Inspectorate very much welcomed the introduction of an information brochure setting out full details of hospital services for patients and their relatives and friends. This brochure was well laid out and attractively presented and contained information on patients' rights and on the local complaints procedure. Patients at the CMH had access to a local shop two days per week; this was appreciated by all.

The management team met on a monthly basis and minutes were kept of meetings. A development committee had been established which met on a fortnightly basis with a view to expediting change within the hospital. A one-day induction process for all new staff had been introduced and there was on-going training and education for staff on CPR, safe lifting, and the management of aggression. Patients requiring ECT treatment were referred to the nearby Clonskeagh Hospital.

In relation to medical records, written instructions on the filing of clinical documentation was required. The patient's name should be clearly recorded on each continuation page; storage of loose clinical material in the medical file should be discouraged, as there were

risks associated with lost or misfiled documentation and delays in accessing pertinent information.

Nursing documentation was of a variable standard. For the most part, basic nursing notes were recorded and these were reasonably up-to-date. Records, mostly in the form of progress notes, identified problems that had arisen and the action taken to rectify them. All nursing notes had the patient's name, date of birth and address appropriately recorded. Ideally, the nursing records should reflect the involvement of patients in planning and making choices and decisions about their own care, albeit within the confines of a secure environment. Similarly, evaluations of nursing care should include patients' views about progress to the various levels of security available within the confines of the CMH. The nursing records should be audited to assess the standard of record keeping and to identify areas for improvement and staff development.

In June of 2001, a survey of patients' experience of care and the need for change at the CMH was undertaken. The Inspectorate very much welcomed this initiative and suggested that the management team review comments from patients with a view to forming conclusions and recommendations, and setting in place an action plan to implement those recommendations in response to patients' wishes.

There were two deaths at the CMH in 2001, one of a twenty-one-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 at the time of the present inspection. A new policy of patient observation was reviewed in January 2001 and implemented in April 2001, with a review date in October 2001. Records on the number of duty spans of special nursing supervision and the number of patients placed on prescribed recorded observations were not available at the end of the year and there was no indication whether this policy had been reviewed. Information relating to complaints or appeals made by patients or their relatives to the local complaints manager in the year 2001 was not available. Neither was information available relating to requests for information under the Freedom of Information Act. A central complaints file should be kept at this hospital, recording the nature of complaints made, the method of handling them and the outcome. Information relating to accidents to patients and staff, assaults on patients and staff, categorised by grade of injury, was not available to the Inspectorate at the time of this inspection. There had been an audit of incidents, based on incident reports; showing forty-five reported assaults on staff in 2001, compared to twenty-six in 1997. There were fifty-four recorded incidents in 2001 that resulted in a patient being placed in seclusion, compared to fifty-one such incidents in 1997. There were forty-three recorded incidents in which control and restraint techniques were used by staff on patients, as compared to fourteen such incidents in 1997.

There was a policy on the prevention and management of violence, sub-headed 'Control and Restraint', which appeared to be in draft form as there was no implementation date or review date and the policy had not been signed off by the management team. The discussions surrounding the policy on control and restraint may have some significance in relation to the increased number of reported incidents in which these techniques were used. The Inspectorate welcomed the seven principles for effective intervention and the

tips for crisis prevention included as an appendix to the CMH policy on the prevention and management of violence. While recognising that physical intervention to deal with aggressive or dangerous behaviour is sometimes necessary in the interest of the patient's safety, the Inspectorate has some reservations concerning the policy itself, particularly in relation to the reference to the use of shields and straitjackets. The Inspectorate was not happy with the terminology 'control and restraint' as it implied that staff had some power over patients, which was not appropriate in any health care setting. The term 'management of aggression and violence' should be used and it should be emphasised daily that any attempt to restrain aggressive behaviour should, as far as the situation allows, be non-physical. The CMH policy should emphasise that 'control and restraint' should be used as infrequently as possible, as a last resort and never as a matter of course. It should be used only in emergency situations when there appears to be a real possibility of significant harm occurring if no intervention is made. The policy should emphasise that any restraint should be reasonable, applied with the minimum force necessary to prevent harm to the patient or to others, and should be used only for as long as is absolutely necessary. The policy should also emphasise the need for staff both to explain repeatedly to the patient the reason for sustaining the action, and to attempt to enlist the patient's support for voluntary control as soon as possible. The policy should also emphasise the need for the patient to see the staff member in control of the incident so that all attempts to communicate appropriately with the patient can be sustained.

There were 785 recorded episodes of seclusion, involving ninety-five patients, at the CMH in 2001. The seclusion policy was reviewed in January 2001, implemented in April 2001, with a review date in October 2001. There was no indication that the review took place. On visiting the clinical areas, it was noted that there were three seclusion policies at some locations; at another location there was a draft policy dated 2000, but no copy of the current policy. All of this was most unsatisfactory. The Inspectorate welcomed the seclusion audit undertaken in February 2002. The audit for the month of February recorded seventy-two episodes of seclusion, involving fourteen patients: three episodes at Unit B, three episodes at Unit A, thirty-two episodes at the female Unit 4 involving a total of 303 hours for the month, and thirty-four episodes at Unit 1 involving a total of 311 hours and 10 minutes. The Inspectorate would like to see a continuation of seclusion audits at this hospital on a monthly basis with the overall aim of reducing the number of episodes and the number of patients placed in seclusion. Facilities for seclusion at the CMH were not structurally appropriate. Some of the rooms used for seclusion were most unsatisfactory and had poor décor. It was noted, particularly in one unit, that seclusion was used by nursing staff and authorised retrospectively by junior doctors who, when eventually contacted, signed the appropriate seclusion book. Seclusion should be used only for the shortest time possible, as a last resort, and to ensure the safety and wellbeing of the patient. Seclusion should not be used as part of a treatment programme and the reference advocating seclusion use as a prescribed treatment intervention in the hospital policy dated April 2001 should be reviewed.

RECOMMENDATIONS

It is recommended that:—

1. Patients residing at Unit 4 and Unit 5 be relocated to upgraded facilities at Unit 2, Unit 3 and Unit A.

2. Seclusion audits be continued with a view to reducing the number of seclusion episodes and improving documentary procedures relating to its use.
3. The seclusion rooms at Unit 1 and Unit 4 be closed and the plan to modernise the patient accommodation in the old building and the provision of in-room sanitation and enhanced day and recreational facilities for patients by the provision of new additions and extensions to the existing buildings be expedited as soon as the option appraisal exercise is completed.
4. The hostel in the hospital grounds be redecorated.
5. Attempts be made to reorganise wards, ward staffing and mix of patients with a view to providing a graded structure of care with security geared at high, medium and low levels to meet patients' needs.
6. Additional rehabilitation residences be provided within the campus for patients requiring low security.
7. The development plan as outlined by the local working group be implemented, especially the plans to upgrade the in-patient accommodation and associated facilities.

CENTRAL MENTAL HOSPITAL — SECOND 2002 INSPECTION

INSPECTED ON 25 NOVEMBER, 2002

GENERAL COMMENTS

The future of the Central Mental Hospital had been the subject of review by a group which reported to the East Coast Area Health Board in the summer. Having been accepted by the Board, the report was then considered by the Eastern Regional Health Authority and accepted in principle. Broadly, the recommendation of the review group was that intensive refurbishment of the old building in the Central Mental Hospital should be undertaken in order to provide a greatly improved service for patients. Refurbishment involved major changes such as adapting all the existing accommodation to en-suite purposes to avoid the current practice of slopping out. Other major changes were also recommended, including the establishment of residential accommodation on the campus or the removing of the perimeter wall to allow some of this accommodation to be outside the present curtilage. There is now a considerable apprehension that, because of the deteriorating national economic situation, this costly endeavour (€26m.) would not take place or would be greatly curtailed. Apart from the major issue of revamping the whole hospital and improving maintenance which was a constant concern of staff with difficulties in getting leaking roofs, defective plumbing and so on attended to in any reasonable period of time, the further major tribulation was the difficulty of nursing/care staff recruitment. Currently, the establishment of 120 was running at twenty-six vacancies. Of those currently in post, forty were nurses and the remainder care staff, several of whom would shortly be retiring. Two care staff were currently undertaking a degree course in nursing and would return to the Central Mental Hospital when their training ended. At consultant level, two further consultants had been recruited, one on a permanent basis and the other temporarily. It was

planned to further expand the consultant staff with a greater remit to the prisons and courts.

There had been considerable re-decoration and some refurbishment of existing accommodation in the old building. Thus, Units 1, 4 and 5 had been re-painted, some Units were closed to patients and, for example, patients in Ward 1 were accommodated in Unit A of the new building but they had since returned to the re-decorated Unit 1 and Unit A had been closed and there were no plans to re-open it in the near future because of staff shortage. However, a recruitment drive internationally had been completed and it was expected that the position would improve. During the time patients from Unit 1 were accommodated in Unit A, seclusion did not take place because there were no facilities for such in Unit A. Since the patients had returned to Unit 1, seclusion had been at a much less frequent level than previously in this Unit and apparently some cultural change had come about for this to occur.

It appeared to be the case that newly admitted patients in Unit 1 were routinely placed in seclusion. The Inspectorate was present when a person with a prior psychiatric history who had been imprisoned, for the first time, in Castlerea Prison was received in Unit 1 having been accompanied there by six prison officers from Castlerea. The Inspectorate interviewed the patient concerned in the seclusion room, in which he had just been placed, and it appeared to be an unnecessary restriction given the mental and behavioural state of the patient and the Inspectorate felt that the situation could have been dealt with otherwise. Seclusion orders were signed for by junior doctors in the first place and, in a minority of cases, countersigned by a consultant. In the case notes inspected, all had entries indicating that seclusion had taken place and the reason why it was deemed necessary. This was a considerable improvement on last year when staff complained that it had been difficult to get junior doctors down to the ward to examine patients, to make seclusion orders and to annotate the medical case notes accordingly.

The Department of Justice, Equality and Law Reform and Department of Health and Children, together with personnel from the East Coast Area Health Board and Central Mental Hospital, had been meeting to formulate a response and service agreement to reduce or end the practice of secluding mentally ill prisoners in padded cells. One suggestion made in this regard was to provide an acute unit in the Central Mental Hospital to deal with short-stay patients, most of whom were remand patients, who otherwise would be secluded in padded cells in prisons, so that this prison treatment of them, considered quite inappropriate by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment and a cause of complaint to the Irish Government, would end. It was suggested that the closed Unit A might be used for this purpose. Obviously, such an arrangement required a quick turnover and thereafter the placement of some patients of this kind within their local services. Local services had not been particularly co-operative in taking back either Section 207 or Section 208 patients, with the result that many of them occupied beds in the Central Mental Hospital unnecessarily. This was particularly evident in relation to Section 208, which over the last decade, had been used, on head of a Supreme Court decision, for the transfer of patients from local district mental hospitals or mental health services to the Central Mental Hospital. The spirit of this section was to enable patients to get time-limited treatment in another hospital, which

was not available in their parent hospital. Despite the Supreme Court decision that the Central Mental Hospital was, for the purposes of this Section, the equivalent of any other psychiatric hospital, there must remain constitutional doubts about its deployment in this fashion. In any case, the aspiration that it would be for a short spell of treatment was dispelled by the fact that one of the 208s had been in the Central Mental Hospital for twelve years, another for nine, another for seven, another for five and another for three years, all of these continuous periods of time. A similar reluctance on the part of referring hospitals to take back Section 207s was also disquieting, although the numbers of 207s now remaining in Dundrum had dwindled to seven.

The Inspectorate was astonished and concerned to find that a practice had grown whereby patients, on the expiration of their temporary patient reception order, had been re-certified in Dundrum and then made the subject of Section 208 orders. This practice was illegal and required explanation on the part of the Central Mental Hospital executive. Patients can only be certified to a district mental hospital and the legal effect of such an order was to have a patient taken to the district mental hospital; it could not be effected in the Central Mental Hospital. In any case, the Inspectorate was determined to explore who made the application, and who supplied the medical certificate in these cases. Furthermore, for a 208 order to be made, the patient must be a patient of and has to be physically present in the district mental hospital to which his temporary order applies.

In addition to serious nurse and attendant shortage, which resulted in much reliance on overtime at a considerable cost, there was no social worker at the time of inspection in the forensic service at the Central Mental Hospital, and no occupational therapist, although the Inspectorate was informed that a psychologist was to take up duty shortly.

There had been two deaths in the Central Mental Hospital since the last visit of inspection in spring of this year, both of them from lung cancer and both of them in-patients who were heavy smokers. This highlighted the former practice of distributing cigarettes and other tobacco products seized by the customs to the residents of the Central Mental Hospital. This practice has now ceased.

Finally, while one was impressed with the considerable internal re-decoration that had taken place in the last year or so in the Central Mental Hospital, one had to state the need for fundamental restructuring and refurbishment as recommended by the Review Group.

PSYCHIATRIC UNIT, ST VINCENT'S HOSPITAL, ELM PARK
— 2002 INSPECTION

INSPECTED ON 5 DECEMBER, 2002

IN-PATIENT CARE

In-Patient care was provided at the twenty-one bed St Camillus psychiatric unit, St Vincent's Hospital, Elm Park.

Age and Length of Stay of all Patients at 31.12.01

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	2	—	1	5	8	80
3-12 Months	—	—	1	1	—	—	2	20
1-5 Years	—	—	—	—	—	—	—	—
> 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	—	3	1	1	5	10	
% of Total	—	—	30	10	10	50	100	

In-Patient Population Diagnosis (31.12.01)

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

Status of In-Patients on the date of second inspection 2002

Status	Male	Female	Total
Voluntary	4	5	9
Temporary	—	1	1
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	4	6	10

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
284		N.A.	N.A.	97.9	2.1	287	0

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	50	133
Day Centres	—	—	—
Out-patient clinics	1	196*	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
7.75	5	16.16	2	4.75

COST

The cost of the St Vincent’s Hospital Service was €1.9 million in 2001.

GENERAL COMMENTS

St Camillus Psychiatric Unit was a stand-alone twenty-two bed unit in St Vincent’s Hospital, Elm Park. It did not form part of the wider catchment area service, although it did admit patients from part of that catchment area and further afield for a specialised eating disorders programme. The Unit also had three beds for the psychiatry of later life service for the catchment Area 1 and catchment Area 2. This Unit had a limited lifespan as it was about to be replaced by a new comprehensive acute psychiatric unit for the catchment area 2 service. This Unit, which was under construction, was expected to be operational in 2003.

Ten of the beds in this Unit were closed at the time of inspection due to acute staffing difficulties. There were only five patients in the Unit on the day of inspection, as compared to twenty patients the previous year.

In the light of the proposed new developments, it was essential that a blueprint for the combined Area 2 St Vincent’s Hospital service be carefully planned and the philosophy of service delivery for the entire catchment area be in accordance with Government policy as set out in *Planning for the Future*. Whilst there was a user group comprising representatives of St Vincent’s Hospital and the nearby community mental health team at Vergemount, it did not meet regularly. More formal meetings, chaired by senior managers, were needed to ensure a smooth transition to an integrated mental health service for the catchment area.

It appeared that the current St Vincent’s service provided a liaison service to the general hospital as well as other groups of hospitals which belonged to the St Vincent’s group (St Luke’s, Rathgar, the Eye and Ear and the Hospice at Harold’s Cross and Hume Street Hospital). This was done without a liaison consultant in place. Clearly, the new conjoined Area 2 service would require a liaison team headed by a specialist consultant psychiatrist. Liaison was significantly better in relation to Holles Street Hospital, where one of the Area 2 consultants worked half-time in liaison consultation work. All of this would need to be rationalised in the context of an integrated mental health service. The East Coast Area Health Board and St Vincent’s Hospital should consider developing a consultant-led liaison psychiatric service for the hospital similar to those already developed at St James’s, the Mater, Beaumont and Tallaght Hospitals.

The Inspectorate very much welcomed the opening of the psychiatry of later life day hospital at Carew House on the campus of St Vincent's Hospital. A day hospital for general adult psychiatry needed to be developed for the area and it should incorporate the new eating disorders day programme that had been developed. The service should consider training and appointing clinical nurse specialists for the eating disorders programme.

There were no ECT facilities at the St Camillus Unit and patients who required treatment were brought to the operating theatres at St Vincent's Hospital. There was no protected time for electro-convulsive therapy and, as a result, patients were left waiting for long periods. A better protocol needed to be arranged. This, of course, should change with the opening of the new integrated unit having its own ECT suite. Seven patients were prescribed electro-convulsive therapy at St Vincent's Hospital last year.

There was a generic safety statement in the Unit and a risk assessment had been carried out in April, 2002. Risks were identified and an action plan put in place. A copy of the risk assessment was available in the local Unit.

There were six involuntary admissions to St Vincent's Hospital last year and one was re-graded to voluntary during the course of hospitalisation. Twelve per cent of all admissions to St Vincent's were to the eating disorders programme. A further eleven per cent were to the psychiatry of later life beds and thirty-three per cent of admissions were from the Accident and Emergency Department following overdose or incidents relating to self-harm. There were 334 general adult liaison consultations and a further 130 consultations by the psychiatrists of the later life team in the wards of St Vincent's Hospital last year. Twenty-six patients were admitted to the Unit following assessment. Of the 287 discharges from the hospital last year, nine patients took their own discharge against medical advice. Procedures were in place to follow up these patients if deemed clinically appropriate. There were no deaths in the St Camillus Unit last year. There were 394 first referrals and 647 return reviews undertaken by the Department of Later Life Psychiatry, which, as previously stated, had access to four assessment beds at the St Camillus Unit.

Information relating to complaints and Freedom of Information requests specific to the Department of Psychiatry, St Camillus Unit, was not available as there was some difficulty within St Vincent's in separating complaints and Freedom of Information requests by specialty. The service user group, comprising representatives of St Vincent's and Verge-mount Clinic, should review this matter prior to the opening of the new integrated Unit. There were two accidents to staff resulting in minor injury at the St Camillus Unit last year. There were forty-five accidents to patients, including nineteen incidents of self-harm, ten of those involving one patient. None of the accidents or incidents were deemed serious, although twelve resulted in minor injuries. There were six assaults on staff and five of those resulted in minor injuries. All staff in the Unit were trained in the management of aggression and violence and a new personal alarm was installed since the last visit of inspection. There was need for a written policy and procedure on the use of the personal alarm. Nursing staff were inducted into the service and a new ward-based orientation checklist was available which required new staff to sign indicating that they had been made familiar with the general layout of the department, location of fire points, evacuation plan, location of emergency trolley and oxygen point and had understood the hospital nurses' handbook, health and safety statement, risk management guidelines and policy and procedure guidelines. All policies and procedures in relation to this service would be reviewed in the context of the re-location to the new acute psychiatric unit.

Information on patients’ rights under the Mental Treatment Act, 1945 and amending legislation should be prominently displayed in patient care areas and included in the orientation handbook, which should be available for patients on admission.

Nursing care plans, using the ‘Peplau Model’ of nursing, were appropriately recorded. However, there was a need for the nurse’s full signature on the assessment part of the nursing records. Loose pages in the nursing documentation were problematic, resulting in lost or misfiled information and delays in accessing pertinent information. All entries in the nursing records included the date and the time using the 24-hour clock, which was very satisfactory. The service had a comprehensive policy on commonly used abbreviations.

RECOMMENDATIONS

In view of the fact that the new Psychiatric Admission Unit was nearing completion, recommendations are confined to the need for the East Coast Area Health Board and St Vincent’s Hospital to work out governance arrangements in relation to the new Unit and to enter into discussions with staff from both St Vincent’s and Vergemount in relation to the opening of this much-needed facility.

WICKLOW MENTAL HEALTH SERVICE — 2002 INSPECTION
INSPECTED ON 4 JULY, 2002

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 89,713 was divided into three sectors as follows:

Sector	Population
North Co Wicklow	30,365
Mid Co Wicklow	29,598
South Co Wicklow	29,750

IN-PATIENT CARE

In-Patient care was provided at Newcastle Hospital, with ninety beds in three integrated units and one high-support residence.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	1	4	12	4	3	24	36.3
3 to 12 Months	—	—	1	2	3	4	10	15.2
1 to 5 Years	—	—	2	2	5	3	12	18.2
Over 5 Years	—	—	2	8	5	5	20	30.3
All Lengths of Stay	—	1	9	24	17	15	66	100
% of Total	—	1.5	13.6	36.3	25.7	22.7	100	

In-Patient Population Diagnosis at (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
7	22	2	8	1	1
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
—	4	—	5	16	66

Status of In-Patients on the date of inspection 2002

Status	Male	Female	Total
Voluntary	34	24	58
Temporary	5	2	7
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	39	26	65

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
576	6.4	160	27.7	90.8	9.2	558	10

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of Persons Attending
Day Hospitals	1	20	144
Day Centres	4	162	266
Out-patient clinics	9	276*	1,242

*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
4	22	4	38	1	22

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
10	10	72	39.5	6.5

COST

The cost of the Wicklow Mental Health Service was €8.4 million in 2001.

GENERAL COMMENTS

The county Wicklow service consisted of three sectors, North, Mid and South. There was continuing population expansion in the North sector and, to a lesser but not insubstantial degree, in the Mid sector. Community-based services were developed to a reasonable degree in the North sector, but were rudimentary in the Mid and South sectors. In-Patient provision, including acute, continuing care and rehabilitation, and care of older patients, were provided in Newcastle Hospital.

It was the Inspectorate’s view that, given the rapidly increasing catchment population and the fact that one of the three different consultants (of whom one was temporary) also was a clinical director, a fourth sector and a consultant-led team should be put in place. It was also felt that a consultant-led specialist team for the psychiatry of later life should be recruited and that a specialised rehabilitation team, consultant-led either on a full-time or special-interest basis, should be provided.

There was a worrying lack of sector-based facilities, particularly in the Mid and South sectors, which lacked sector headquarters, mental health centres and day hospitals. All of this was acknowledged in the seven-year development plan that the service had produced for the East Coast Area Health Board. Additionally, those services that were available in the North sector needed strengthening and expansion. The board was about to purchase one house and an industrial unit in Arklow; one of these would replace the existing day centre, and the second house would provide community residential accommodation. As well as providing improved physical resources in the sectors, the social work, psychology and occupational therapy components of the service needed strengthening.

The in-patient base at Newcastle consisted of sixty-five in-patients on the day of inspection. Of these, thirty-four were male and thirty-one were female. Twelve were of temporary status. There were three components to the in-patient service. The first was the thirty-two-bed admission ward, which contained twenty patients, the second was a ward for the care of older persons, most of whom had organic degenerative conditions, and contained twenty-nine patients, and the third was a rehabilitation/continuing care residence with sixteen patients.

The issue as to the future location of the acute in-patient service was one that had been only partially addressed in the seven-year planning document. If the county Wicklow service was to follow national policy in providing acute in-patient care in a general hospital setting, then the only available hospital of this type was located just outside the catchment area, in Loughlinstown. However, the major population of the catchment area was in the North Wicklow sector, around Bray, and therefore nearer to Loughlinstown than to Newcastle. This consideration appeared currently to be a remote rather than a live issue. The Inspectorate would like to see a greater commitment to its consideration than was currently the case. Newcastle provided a liaison consultation psychiatric service to those patients using the Loughlinstown services who resided in the Wicklow catchment area but,

in addition, a further liaison psychiatric service was provided by the Cluain Mhuire service by a new consultant appointment, which also serviced St Michael's Hospital, Dun Laoghaire, on a liaison basis.

The second component in Newcastle Hospital concerned older persons and, apart from one younger patient who was deemed unmanageable anywhere else, all occupants were suitable for nursing home care or for the specialised general services for older persons, rather than those for psychiatry.

Finally, the rehabilitation/continuing care component, Avondale, which was on the psychiatric register, did not need to be and, in the Inspectorate's view, should be de-designated so that, in theory as well as in practice, this residence, Avondale, would become what it already was in practice, a high-support residence. In this regard, however, it appeared that a detached premises in its own grounds in the vicinity of Newtownmountkennedy, was to be made available to the psychiatric service and was of sufficient size to accommodate all persons currently in Avondale who, on transfer, would allow the main Newcastle building to close to psychiatric care. Between the acute admission and elderly care units, a very useful visitors' centre had been put in place, as described in the body of this report, and was regarded as a very valuable further asset to facilities in Newcastle. In addition, a newly created, landscaped garden, providing a quiet and peaceful haven for the older persons unit, had been opened in the past eighteen months. There were two low-support community residences, both former medical residences, on the Newcastle campus. Finally, it was planned that the ECAHB intended, when funds allowed, to provide an intensive care unit on the grounds of Newcastle Hospital.

A feature of the Wicklow mental health service was the extensive and comprehensive documentation available on all aspects of service provision, including documentation for patients. Booklets existed for patients explaining the functioning of the service to them and separate individual leaflets existed for patients and relatives concerning individual medication treatments and ECT. In addition, the service produced a guideline booklet for relatives and friends on coping with attempted suicide. An annual nursing report was produced each year. An informative booklet on alcohol-related problems for patients and families was also available. There was a commitment to reducing the alcohol-related admissions to acute in-patient care for detoxification purposes, which currently accounted for approximately one-fifth of all admissions to the service.

Medical case note structure and organisation was of a reasonably high quality and generally informative, although an improved top sheet would be more helpful. The notes were comprehensive and detailed the reason for admission (although the paths to admission, and why alternatives were not considered, were not always apparent) and usually set out clearly a treatment plan. There were also details of intake conferences at team meetings and a care programme approach to each case. However, numerical ICD diagnostic codes were not always apparent. For each first admission there was a separate medical assessment form completed, which was incorporated into the medical record and was of considerable value.

Nursing care plans followed what was called the 'Newcastle' model, which was an adaptation of a number of systems to local need and custom. These care plans were inspected and appeared to be of high quality and well maintained for the initial evaluation and during clinical progress. Nursing staff wore identification badges and a primary nurse care system operated. As well as trained staff, Newcastle provided experience for student nurses from a variety of different settings.

Prescription documentation was generally of high standard and individual signatories provided signatures on arrival at the service. There was a tendency to group prescribing dates and discontinuation dates and it was suggested that each prescription should be individually dated and signed for, both on initiation and discontinuation. Notices of patients' rights were prominently displayed and, in addition, explained on an individual basis to patients, as was information relating to complaints procedure. A written policy and procedure relating to patients absenting themselves without leave was in place, as was similar documentation relating to seclusion.

Seclusion was rather frequently employed in the service. It was suggested that some review of the frequency issue should be undertaken. Seclusion orders were signed for either by a consultant or junior hospital doctors in the first instance and, in the latter situation, were counter-signed by a consultant. Nursing case note registration of seclusion episodes and the reasons why these were deemed necessary were generally entered in medical and nursing documentation. The seclusion room itself had been attractively painted with county Wicklow landscapes by a member of the nursing staff, thus reducing the intimidatory nature of the experience. The observation facilities for acutely ill patients in the admission unit were not entirely satisfactory. No area was directly visible from the nurses' station, but three high-observation beds were available in one space, which had to be accessed through the day room and which was under camera surveillance from the nurses' station. This was not an entirely satisfactory arrangement and some thought should be given to modifying or changing it. When a patient was placed in seclusion, however, a nurse occupied the observation desk directly opposite the entrance to the lobby leading to the seclusion room and, here again, camera surveillance was available.

Special nursing was relatively infrequent in the unit, but a graded nursing observation programme was in place; by this was meant that patients deemed to be in need of special supervision were reviewed on a fifteen-minute or longer interval basis and these observations were recorded. In consequence, the admission unit was an open unit under all ordinary circumstances, closing only at 9.00 p.m. The admission unit also benefited from the presence of a ward clerk who had her own office in the visitors' centre. This person carried out a randomly based survey of patients' satisfaction on a large sample of admitted patients and the results of this were available to staff and guided policy in relation to patient comfort and care.

There was a dedicated ECT suite and the anaesthetic component was administered by consultant staff from Loughlinstown Hospital. Generally speaking, patients did not have to wait unduly for treatment, which was administered in the morning. Unusually, consultant

anaesthetist staff might be held up at Loughlinstown Hospital but, in such cases, communication was made with the dedicated ECT nurse and arrangements were made to provide snacks for patients, who were informed of the unfortunate delay, and reassured. There was a dedicated ECT consultant psychiatrist as well.

A close-knit management existed in Newcastle, which met frequently and provided minuted accounts of meetings. In addition, there were sector meetings and team meetings occurred in all three wards once a week. All new staff underwent an induction process. The service was accredited by the Royal College of Psychiatrists for training purposes. It was experiencing some difficulty in recruiting suitable psychiatric trainees; there were currently three general practice trainees in post. There was a satisfactory induction course for new doctors arriving in the service.

Three patients were randomly selected for interview by the Inspectorate to assess their opinion of the services provided them. Two were female and one male and they ranged in age from twenty-five to forty-five years. One was a first admission, the other two had had more than one previous admission to this unit. All were quite positive about the services provided them. All were quite pleased with their interactions with nurses and doctors. The relevant consultant psychiatrist met with patients about three times per week and their medical conditions, medications and side effects were fully explained to them. All had been involved with their key nurses in formulating their nursing care plans. On admission, each had received literature about relevant hospital policies, etc., and they were aware of their rights under the mental treatment legislation. All were satisfied with the dignity and respect afforded them. One of the patients was on a detention form but fully accepted this and realised that in the not too distant future voluntary status would be conferred. When questioned as to how the services could be improved, one replied that the services were 'spot on' and made no suggestion as to improvement. The second said that outdoor activities would be appreciated but readily agreed that the inclement weather was a major factor in preventing this, while the third patient said that more frequent access to the OT department would be beneficial.

Finally, it was necessary to acknowledge the very considerable contribution that had been made by the voluntary organisation 'Friends of Newcastle Hospital' which, through fund-raising, the running of fetes, etc., had realised considerable funds for numerous developments in the Wicklow mental health service.

RECOMMENDATIONS

It is recommended that:—

1. A fourth sector be created in the county Wicklow Mental Health Services catchment area.
2. A specialised service for later-life psychiatry be put in place.
3. A dedicated rehabilitation service be instituted, led by a consultant psychiatrist, either on a whole-time or special-interest basis.
4. Physical resource provision in the sectors be either augmented or instituted, making sector headquarters/mental health centres and day hospitals available in each sector.

- 5. The multi-disciplinary staff be increased in each sector by the recruitment of additional social work, psychology and occupational therapy professionals.
- 6. Additional high-support community residences be acquired, beginning with the acquisition of the proposed house near Newtownmountkennedy to enable the Avondale unit to close and, in the interim, patients currently in that unit in Newcastle Hospital be de-designated.
- 7. Serious consideration be given to the provision of an acute in-patient psychiatric unit in Loughlinstown Hospital to replace the current facility in Newcastle Hospital.

SOUTH-WESTERN AREA HEALTH BOARD

DUBLIN SOUTH CITY MENTAL HEALTH SERVICE

PSYCHIATRIC UNIT, ST JAMES’S HOSPITAL — 2002 INSPECTION

INSPECTED ON 18 DECEMBER, 2002

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

IN-PATIENT CARE

In-Patient care was provided at the Jonathan Swift Clinic at St James’s Hospital which had fifty-one beds. In addition the service had access to thirty-four beds for continuing care at St Patrick’s Hospital. These beds were contracted from the Private Hospital by the South Western Health Board.

Age and Length of Stay of all Patients at 31.12.01

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	1	12	13	2	5	33	70.2
3-12 Months	—	—	6	2	2	1	11	23.4
1-5 Years	—	—	—	1	1	—	2	4.3
> 5 Years	—	—	—	—	1	—	1	2.1
All Lengths of Stay	—	1	18	16	6	6	47	100
% of Total	—	2.1	38.3	34.0	12.8	12.8	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	16	26	17	7	—
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
3	1	—	—	1	47

Status of In-Patients on date of inspection, 2002

Status	Male	Female	Total
Voluntary	14	18	32
Temporary	8	7	15
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	22	25	47

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
468	4.8	N.A.	—	89.7	10.3	444	0

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	2	95*	30
Day Centres	1	16	16
Out-patient clinics	N.A.		

*One 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
15	5	50.5	N.A.	11.5

COST

The cost of the St James’s/Area 3 Mental Health Service was €8.89 million in 2001.

GENERAL COMMENTS

The catchment area service of Dublin South City (Area 3) comprised the Jonathan Swift Unit in St James’s Hospital, the day hospital and continuing care facilities in St Patrick’s Hospital and the community services were administered by St James’s and St Patrick’s Hospital on behalf of the South-Western Area Health Board. The Former Clinical Director of this service was also the Academic Professor of Psychiatry in Trinity College. With the retirement of the Clinical Director, the management structure had changed through agreement with all parties. The Clinical Director post was now solely responsible for the clinical services reporting to a Board comprising the Chief Executives of St James’s and St Patrick’s Hospitals and representatives from the South-Western Area Health Board. A business Unit Manager and an Area Manager had been appointed to assist the Clinical Director. The Academic Professor of Psychiatry had six clinical sessions and was accountable to the Clinical Director for those sessions.

The new orientation and commitment to providing “care in the community” was exemplified by the creation of two sectors, Camac sector in the North and Owendoher sector in the South. The Camac sector was further sub-divided into two sub-sectors, supported by a multi-disciplinary consultant-led team, although some disciplines, such as psychology, serve two sub-sectors. The Owendoher sector was serviced by one and a third clinical teams. Additionally, the Camac sector would shortly absorb 36,000 extra population from Area 4, largely constituting the Drimnagh area. A consultant-led team in general adult psychiatry was to be appointed to look after this additional population. St Martha’s House on the South Circular Road should open very shortly to serve as a sector headquarters and a day hospital for the two Camac sectors. It was the ambition of the service to replicate this community involvement with a similar sector headquarters and day hospital for the two Northern sub-sectors, comprising Owendoher on the land owned by the service in Terenure. This development was awaiting capital funding. In addition to the services for general adult psychiatry, Area 3 had a specialised service for the psychiatry of later life and nine acute assessment beds in the Conolly Norman sub-unit on the ground floor of the Jonathan Swift Unit of St James’s. This service also had a day hospital, Martha Whiteway, located in St Patrick’s Hospital. It was intended to transfer this day hospital for the elderly from St Patrick’s to the ground floor of the St James’s Psychiatric Unit, also known as the Jonathan Swift Clinic. This was dependent on the general adult day hospital moving from its current location on the ground floor of the Swift Clinic to St Martha’s on the South Circular Road.

St Patrick’s Hospital on behalf of the South-Western Area Health Board operated the community component of the Area 3, Dublin South-Central psychiatric service, administratively. A pending change in this arrangement was evident by the proposed movement of the elderly day hospital from St Patrick’s to the St James’s Unit and the virtual elimination of long-stay area patients, which numbered well over thirty, from St Patrick’s to alternative locations. Initiatives characterising this service was; the setting up of a patient advocacy network through an organisation called Voice, an extensive risk evaluation audit

and management system, and improvement in a number of documented policy and procedure items. It was also intended to initiate a referral and admission arrangement which would identify a named senior member of management in both the St Martha's Mental Health Centre/Day Centre and the Terenure equivalent when it was established, to all referral agents, particularly general practitioners so that referral to the two centres would be a regulated process, assessment taking place in both centres and decisions then made by the recipient medical personnel, in consultation with their consultant colleagues. All referrals, out of hours, would continue to be directed to the Accident and Emergency Department of St James's Hospital for assessment by the consultant-led liaison psychiatric service, but the consultant psychiatrist was only available from nine to five. These formalised procedures should eliminate the indiscriminate arrival of patients in the unit and lead to more discriminating practices towards admission, or community-based alternatives when these were deemed appropriate.

The main adult patient area in St James's, located in its acute component on the first floor, was outdated in design for modern psychiatric acute in-patient practice, with poor facilities for observation and very limited day space for patients. This could account for the graffiti, which adorned the smoking room in the Fownes Ward. Neither seclusion nor special nursing to any great degree was practiced in Fownes. The acute ward, Beckett, the Conolly Norman unit for the elderly, the occupational therapy department and the day hospital were located downstairs. The day hospital was to move to St Martha's and, as a prelude to this day patients no longer dined in the St James's Unit.

The case note procedure was an integrated one with nursing care plans and medical clinical notes in the same case folder, although note-taking was of moderate quality and as, in several instances, new admissions were not seen by consultants for several days. The Inspectorate was unable to identify any formal intake assessment or planned programme in which the patients had participated. Whilst medical and nursing evaluations were clearly documented, no spaces were left for ICD diagnoses and this perhaps reflected the lack of formal intake consultant-led evaluations.

Forty-six patients were admitted on temporary certificates to St James's Hospital, twenty-eight male and eighteen female. Three patients admitted voluntarily were re-graded to involuntary during the course of their hospitalisation and one patient, admitted as an involuntary patient was re-graded to voluntary status whilst hospitalised. This service provided a liaison consultation service to St James's Hospital but the service was unable to provide statistical information for the year 2001 relating to the number and outcome of all liaison consultations. An appropriate system was in the process of being set up to capture this data. Three patients from this service were transferred to the special care units of St Brendan's Hospital during the year. There were no deaths during 2001 and none of the patients took their own discharge against medical advice from the in-patient units during the year.

There were two formal complaints made to the local complaints appeals manager and one request under the Freedom of Information Act. All appeared to have been dealt with satisfactorily. Seclusion was not used in this service. Three patients were placed on 'one

nurse to one patient' special nursing supervision, and there were twenty-eight episodes of special nursing supervision during the year. There were thirteen recorded accidents to patients and one of these was deemed serious. There were seven recorded assaults on patients by other patients. Four of these assaults resulted in minor injury. There were ten recorded assaults on staff and four of these resulted in mild injury, scratch or bruising.

Ten patients were prescribed electro-convulsive therapy at St James's during the year. The arrangements for ECT were all satisfactory. There was a dedicated ECT suite comprising waiting 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. 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. Records should be made in the patient's notes that the patient understood fully the nature of the procedure and these details be recorded in the clinical notes. An ECT prescription card should be introduced with the name, hospital number, name of patient's consultant psychiatrist, and patient's diagnosis using appropriate ICD number. The prescription card should have a section setting out the indications for ECT as may be relevant, for example, resistant to anti-depressant, too distressed to await response to medication, suicidal ideation patient prevalent. The card should contain a small checklist to ensure patient's informed consent was obtained and to record whether the patient had ECT previously. The clinical response to ECT should also be recorded on this card, indicating whether the patient was improved, disimproved, or had not changed at weekly intervals after the treatment, and at the end of the course of ECT treatment. The doctor should record such therapeutic response. In addition, the patient should be asked how he or she felt as compared to how they felt before ECT. The patient should be asked to state whether they felt worse, no change, a bit better, much better or 100% well. An information factsheet with the intention of answering questions patients might have following prescription of ECT was made available to patients prior to a course of ECT treatment.

A written drugs policy and procedure was available which included written instructions for the use of prescription cards. All prescriptions were signed and dated individually and were clearly legible, posing low risk of drug error. There was provision for the recording of drug allergies and drug sensitivities but this was not always completed in the cards examined. If there were no known drug allergies or sensitivities, this should also be recorded.

All patients at the Jonathan Swift Unit had easy access to the hospital shop, accompanied by staff members. There was a smoking policy and a designated smoking area, with all areas in the ward non-smoking. The patients' money management system appeared satisfactory but some method of informing patients of hospital charges was required. A procedure for seeking feedback from patients and patients' families on service provision should be introduced. There was a consumer council or patient representative body in this service, chaired by one of the social workers. Meetings consisted of introduction, review of minutes and all business related to the unit. This body could also conduct the consumer satisfaction survey and produce reports. Policies, procedures and practice guidelines were reviewed in this service during the year 2000. Clear definitions between policy, protocol

and clinical practice guidelines were available. Each policy had an individual cover sheet detailing reference numbers, authors of the policy, who reviewed and approved the policy, effective date, what the policy replaced and review date. All of this was very satisfactory. There was a policy and procedure relating to the management of illicit drug use or drug-related incidents, setting out action to be taken if suspicion of illicit drug use or supply occurred, and policy for staff to confiscate illicit drugs/alcohol and dangerous weapons. In addition, a treatment contract was entered into with any patient suspected of using illicit drugs. The quality of the policy documentation was high and it was good to see risk management and quality management inextricably linked in this service. The system of reporting and documenting incidents and accidents was satisfactory. Health and safety statements were up to date and a copy of the latest safety audit was available on the unit. There was a fire and safety committee for St James's Hospital and the Jonathan Swift Unit was represented. The service had recently formed a risk management group and this was formed to review all aspects of safety.

Whilst information on patients' rights was prominently displayed at the Jonathan Swift Unit, there was no indication whether this information was brought to the attention of patients. Service providers should consider establishing a system of verification using a standardised form to record that this information has been given to patients. The form should have space for recording; 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. It was recognised that there could be difficulties in explaining legal matters to patients whose mental state could preclude the understanding or retention of such information. It was therefore important that rights were explained as far as possible in a way the patient could understand. If the patient was clearly incapable of understanding, this should be recorded and the information should be repeated at regular intervals using professional judgement to decide on the patient's capacity for understanding.

Nursing records consisted of historical and personal data, assessment details, a nursing assessment interview, a nursing care plan and nursing notes. The patient assessment form was well completed and the nursing assessment interview was well documented in all notes examined. Patients blood pressure, weight, urine analysis and temperature, pulse and respiration were all recorded and documented on admission, with the exception of one nursing note and no reason was stated as to why this was not done. There was provision for recording known allergies but this was not recorded. Records examined identified problems that had arisen and actions taken to rectify them. These identified problems were nurse-led. Whilst this was appropriate, provision should be made for recording the patient's own feelings and the records should reflect the involvement of patients in planning and making choices and decisions about their own care. Similarly, evaluations of nursing care plan should include patients' views about progress. Abbreviations were noted in day nursing records and there was an appropriate hospital policy on the use of recognised abbreviations. This abbreviations policy was quite comprehensive. Whilst nursing staff at this unit wore identification badges, patients had great difficulty in reading them. A magnetic lapel badge with the name and designation of the staff member should be introduced so that patients can easily identify staff members.

Three patients were randomly selected to assess their opinions on the quality of the psychiatric services provided. One was a teenager of temporary status on a first admission and had spent some eight days in hospital. Another patient on a first admission was of voluntary status and had spent three weeks in hospital, while the third patient was of voluntary status on a fourth admission and had spent just over 8 days in the hospital.

All three patients were quite *au fait* with their therapeutic teams. They were particularly pleased with their nurses and doctors and had ample access to and consultation with them. One patient had had access to a psychiatric social worker and was very pleased with this intervention. At all times, the patients were very pleased with the dignity and courtesy extended to them. None of the patients were aware of a hospital explanatory booklet, which surprised the Inspectorate as such booklets were freely available in all patient areas. In future each patient should be formally handed such booklets on admission and sign a record that they have received them.

All three patients were aware of their rights under the Mental Treatment Act, 1945 and were also aware of complaints procedures. One patient was not satisfied with the amount of information provided concerning their illness and would like to have written information on both the illness and its treatment. All felt they were reasonably well involved in the formulation of care plans.

Two patients were very satisfied regarding the general ambience of the unit such as décor, hygiene, heating, quality and quantity of food but one patient had reservations about the bathroom and toilet facilities.

When asked how they would like to see the services improved, one patient was quite happy with things as they were, the second patient would like more interesting therapeutic activities as the evenings and weekends were considered boring, while the third patient said an increase in the nursing complement would be appreciated.

RECOMMENDATIONS

It is recommended that:—

1. The St Martha’s Home function as a Sector HQ and general adult day hospital for the Camac Sector.
2. The capital resources be provided as soon as possible to enable the proposed Owendoher mental health centre and day hospital be put in place.
3. Additional community residential places be provided.
4. The Drimnagh Sector transfer from the Area 4 catchment area to St James’s Service.
5. The day centre be developed at the Meath Hospital in the space allocated for that purpose.
6. The day hospital for the later-life psychiatry service relocate from St Patrick’s to St James’s Hospital.

DUBLIN SOUTH WEST MENTAL HEALTH SERVICE, TALLAGHT HOSPITAL
PSYCHIATRIC UNIT AND ST LOMAN’S HOSPITAL — 2002 INSPECTION

INSPECTED ON 23 OCTOBER, 2002

GENERAL DESCRIPTION OF THE SERVICE

The population of the catchment area was 258,028 and it was divided into four sectors as follows:—

Sector	Population
Crumlin/Drimnagh/Walkinstown	77,877
Tallaght/Rathcoole	74,020
Ballyfermot/Chapelizod/Palmerstown	57,057
Clondalkin/Lucan	49,074

IN-PATIENT CARE

In-Patient care was provided at Tallaght (AMINCH) Hospital and at St Loman’s Hospital where seventy-two beds were provided in one male, one female unit and one Rehabilitation Unit.

Age and Length of Stay of all Patients at 31.12.01

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	1	23	7	5	—	36	62.0
3-12 Months	—	—	6	5	—	—	11	19.0
1-5 Years	—	—	3	3	1	—	7	12.1
> 5 Years	—	—	1	3	—	—	4	6.9
All Lengths of Stay	—	1	33	18	6	—	58	100
% of Total	—	1.7	56.9	31.0	10.4	—	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	25	2 (poss.)	9	10	4
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
1	3	1	2	1	58

Status of In-Patients on the date of inspection 2002

Status	Male	Female	Total
Voluntary	29	20	49
Temporary	7	9	16
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	36	29	65

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate	No.	% of all	Voluntary	non-voluntary		
700	2.7	168	24	88	12	676	3

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	4	58	1,533
Day Centres	3	72	878
Out-patient clinics	5	805*	13,600

*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
6	39	4	43	3	43

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
24	29	220	32	14.5

COST

The cost of the Dublin South West Mental Health Service was €18.9 million in 2001.

GENERAL COMMENTS

A Project Team had been established to progress the re-development of the St Loman’s Hospital site and to devise a development control plan to ensure the orderly and phased development of the hospital campus, which included the demolition of the existing buildings and the provision of a new health facility on the campus. A twenty-two bed psychosocial rehabilitation center had been constructed inside the main gate of St Loman’s. This building was nearing completion and would replace Unit F, in four to six weeks after our inspection. In addition to patient accommodation, the catchment area management team and the occupational therapy department would locate to this new facility. Internally, this building was quite spacious and attractively decorated. It was a major advance to see rehabilitation patients moving from unsatisfactory physical conditions to new (albeit temporary) facilities on the hospital campus. Unit F was the last remaining ward in the original St Loman’s Hospital. On closure of this unit, plans were to demolish the building and a new access road and further ancillary work was to be undertaken with a view to providing enhanced facilities for the patients currently residing at Beech Haven and St Joseph’s, each with twenty-five beds catering for long-stay elderly patients. Both units

were converted some time ago to cater for elderly patients. The upgrading of Beech Haven and the provision of new beds, dining room and sitting room furnishings and curtaining has made this unit more homely and welcoming. The adjacent garden allowed unrestricted access to fresh air for patients. It was well-maintained and safe.

The entrance foyer to St Loman's was unimpressive with dirty windows, poor décor and an overall general run-down appearance. Some upgrading and redecorative work was required at the St Joseph's Unit. The sanitary facilities particularly, the bathroom and shower areas required improvement. Broken furnishings and furnishings with torn upholstery constituted a serious fire hazard and should be removed. There was an emergency drug box however it was some three weeks past expiry date. A system of checking the emergency box and emergency equipment on a weekly basis should be introduced and appropriate records of all checks kept.

The catchment area with a population of 258,000, was divided into four sectors and further sub-divided with two multi-disciplinary teams operating within each sector and sharing facilities. Following a recommendation on previous reports, it was noted that agreement had been reached between the St Loman's and St James's services relating to catchment area boundaries. The Drimnagh sector with a population of 34,000 was scheduled to transfer to the nearby St James's service. This was a much welcomed development. Since the previous inspection, two additional psychologists had been employed in this service and there were a further two vacancies for clinical psychologists. Seventeen psychiatric nurses from overseas were recruited and most had integrated well into the service. Improvement in the clinical psychology service and the commitment of the local management team to filling existing vacancies were welcomed. There were twenty-nine nursing vacancies in the service which continued to depend to a large extent on overtime and agency nurses. Four more nurses were scheduled to leave this service in the weeks following this inspection.

The scouts' den facilities at Clondalkin, rented by the board and run as a day centre, were run-down and very dilapidated. Following previous recommendation, the management team had plans to re-locate to alternative premises nearby. The delay related to planning approval for change of use.

The Department of Later Life Psychiatry had integrated into the adult psychiatric programme with a reporting relationship to the Assistant Chief Executive Officer with responsibility for mental health. Two community mental health nurses had been appointed to this service since the previous inspection. The service was having difficulty in filling the approved occupational therapy post. The assessment beds at the Aspen Unit of Tallaght General Hospital remained closed due to staffing difficulties. Information relating to the number of patients on the register of the Department of Later Life Psychiatry, the number of referrals, home domiciliary assessments and activities at out-patient departments was not available. Statistical records of activity levels should be kept and priority should be given to the opening of the Aspen Unit. Some re-assessment of the skill mix and skill substitution should be undertaken with a view to ensuring that this necessary service becomes operational as soon as possible. The issue of mentally infirm persons who had

grown old in the care of the mental health service was to be addressed through the provision of adequate residential facilities, which would replace the out-dated facilities at Beech Haven and St Joseph's Units on the St Loman's Hospital campus. There were plans to re-locate some patients from Beech Haven and St Joseph's to alternative care facilities, freeing up a number of beds at these locations as long-stay continuing care beds for the Department of Later Life Psychiatry.

One liaison consultant psychiatric post and one rehabilitation consultant psychiatric post had received approval and were filled in an acting capacity. In addition, two general adult consultant psychiatric posts were filled in an acting capacity. Agreement had been reached between the health board and the Adelaide and Meath Hospitals, Dublin incorporating the National Children's Hospital (AMINCH) on the split of consultant sessions and the rehabilitation and two general adult psychiatry consultant posts were to be filled early in 2003. The consultant post in liaison psychiatry was put on hold pending further discussions.

This inspection included a visit to the Mary Mercer Centre in Tallaght, a one-stop health facility with a section for the exclusive use of the mental health service. The mental health services used this premises on two afternoons per week and the facility was unused thereafter. No staff or patients were present at the time of the visit. There were plans to close the Maybury Road clinic so that all out-patient clinical sessions would be held at the Mary Mercer Centre. A greater utilisation of these facilities would be most welcome.

At the time of inspection, discussions were underway with a local developer regarding exchange of land at St Loman's in return for the provision of three five-bedroomed group homes for the mental health service. Plans to sell part of the site and the public/private partnership to build new facilities for Beech Haven and St Joseph's were also under active consideration. All of these developments were welcomed.

The Ballyfermot Mental Health Centre required external re-decoration. Internal ventilation was poor and the Centre had difficulties with mice infestation. There were also difficulties relating to vandalism and break-ins. Replacing this facility with a more substantial building was under consideration. The high-support community residence at Armagh Road worked well but because of its large size was institutional in nature. There were high-maintenance costs associated with the building. A new house at Newcastle, Co Dublin purchased some two years ago remained idle. This facility, described in the body of the report, required some refurbishment, installation of a fire alarm and appropriate fire doors to ensure it complied with fire safety regulations prior to the issuing of a fire certificate. This was an ideal location for a high-support community residence and there was potential for further development on the site as the Newcastle and Saggart area was scheduled for substantial development. Any plans to sell this premises should be reviewed in the context of the need for adequate facilities in a developing area.

Health and Safety audits had been conducted in the service but the service providers were having difficulty in securing funds to address problems identified. There was an estimated cost of €2.5 million to meet health and safety issues in group homes and ward areas. All

health and safety issues should be prioritised according to the degree of risk and a planned programme put in place to address issues according to priority.

There were plans to re-locate the day hospital and the day centre from the Glen Abbey premises, Belgard Road, to a new exchange building adjacent to AMINCH hospital in Tallaght. The alcohol counselling programme currently located at Glen Abbey would remain. As there was a lot of development within this catchment area, it was suggested that the management team produce an annual report outlining the year's achievements and highlighting the strengths and weaknesses of current service provision.

There were eighty-four involuntary admissions to the acute unit last year, forty-seven male and thirty-seven female. Four of these patients were re-graded to voluntary status during the course of their hospitalization. Seventeen patients, thirteen male and four female, admitted as voluntary patients, were re-graded to temporary status during the course of their hospital stay. There were no extensions of involuntary temporary admission forms during the latter half of last year. Fifty-nine patients took their own discharge from the mental health service against medical advice during the year. Procedures were in place for the follow-up of those patients if deemed clinically appropriate.

Twenty-four patients were placed in seclusion at the acute unit in 2001 and there were eighty episodes of seclusion during the year. We were pleased to report that the local service providers accepted recommendations last year concerning the inadequate seclusion rooms and there were plans to upgrade these rooms to a more satisfactory and less intimidating standard. A seclusion register was maintained and seclusion authorisations were made by consultant psychiatrists or junior doctors, with thirty-seven episodes of seclusion recorded from 1st January, 2002. Fifteen-minute nursing observations were recorded. It was not possible for us to check this as the recorded observations were in clinical files of the patients who had been discharged. There was no current policy relating to seclusion. A policy was in draft form but was awaiting approval and effective date and review date. This should be done as a matter of urgency.

There were 846 episodes of special one-to-one nursing supervision involving twenty-four patients last year, a substantial reduction from the previous year. The use of special nursing supervision should be audited on a yearly basis and should include reason for observation, length of time observed and any untoward incidents. Records should be kept of the patient's view on the progress of special supervision. A system of prescribed recorded observations should be considered as an alternative to special supervision and as a means of checking on the whereabouts of patients at risk and reducing the number of episodes of special nursing.

Forty-seven patients were prescribed electro-convulsive therapy last year. Arrangements for ECT were satisfactory. There was a dedicated ECT suite, comprising three or more rooms, including a separate waiting and recovery area. A policy for ECT was in draft form and a copy of the Royal College of Psychiatrists Handbook was available. A named consultant psychiatrist was responsible for the ECT clinic and the induction of junior doctors. The consent form in use was satisfactory. There was a pre-ECT nursing checklist.

It was suggested that this be reviewed and a pre- and post-ECT nursing checklist be introduced.

There were no complaints made to the local complaints manager last year. There were eight requests under the Freedom of Information Act and all appeared to have been dealt with satisfactorily. The rights of detained patients were prominently displayed in in-patient care areas. An entry should be made in the patient's nursing process documentation that an oral and written explanation of patient's rights had been given with an indication of the patient's comprehension. If the patient was clearly incapable of understanding, this should be recorded and the process repeated at regular intervals using professional judgement when deciding on the patient's capacity for understanding. Management should closely monitor the handling and outcome of all informal complaints, both to ensure minimum delay and to note any quality implications arising from informal complaints.

There were fifteen recorded accidents to patients and five recorded accidents to staff at St Loman's Hospital last year. Seventeen of the accidents resulted in mild injury and one accident to a patient was deemed serious. There were four recorded assaults on patients by other patients and six recorded assaults on staff. Nine of the assaults resulted in minor injury, scratch or bruising. There were thirty-two recorded accidents to patients and six recorded accidents to staff at the Tallaght unit. Twelve of the accidents resulted in minor injuries. Two of the patient's accidents were deemed serious. There were six recorded assaults on patients by other patients resulting in minor injury during the year. There were thirty-three recorded assaults on staff. Twenty-eight resulted in minor injury, scratch or bruising and two were deemed serious.

The importance and value of policies, procedures, guidelines and similar documentation had been recognized. A multi-disciplinary committee had reviewed policies and these were in circulation in draft form. Whilst the production of policies and procedures is an onerous task and difficult to achieve, it is necessary that these be ratified and introduced formally to relevant staff, ensuring awareness and understanding of content. Relevant training and education should be given if policy content affects current practices. Staff should sign to say that they have read, understood and are able to comply with the policy content. There was also a need for regular review of policy validity and the incorporation of an audit process to enable assessment of efficacy and compliance.

The management team of this service met regularly and appropriate minutes were kept. There was a fire and safety committee that met monthly and minutes were kept. There was an induction process for all new staff and appropriate records kept. Training for staff on cardio-pulmonary resuscitation, safe lifting and the manual handling of loads and the management of aggression and violence were ongoing. All health and safety statements were reviewed and updated since the last inspection. There was a need for development of a written complaints procedure, which should be brought to the attention of patients and relatives at the Tallaght acute unit. This could be included in a hospital information brochure for patients. All patients in the Tallaght unit had unrestricted access to fresh air and adequate access to the shop on the hospital grounds. The safe rooms, bathrooms and toilets at Tallaght Hospital required refurbishment.

A number of clinical files were examined as part of this inspection and 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 the clinical notes. Some entries to the clinical notes were unsigned and some of the signatures were illegible. The person making the entry should print their name in block capitals and state their designation before their signature of the first entry to ensure easier identification of the practitioner in the future. There was a need for written instruction on filing of documentation within the record and the storage of loose clinical material within the file should be reviewed as there were risks associated with misfiled information or delays in accessing pertinent clinical information. Whilst there was provision for the recording of the patient's name on each continuation page, this was not always completed in the notes examined.

The written policy for ordering, prescribing, storing and administering of medicines was in draft form and needed to be ratified with an appropriate effective date as soon as possible. The legibility of individual prescriptions examined were reasonably satisfactory. Prescriptions were signed and dated individually with one date and one signature for each prescription. In a small number of prescription cards, the start date and the stop date were not always completed. On a number of cards, it was noted that discontinued prescriptions were greater in number than current prescriptions and, as there was an increased risk factor of drug error, it was suggested that these cards be re-written. Provision should be made for the recording of the nurse's signature in full when the drug administration recording card was next reviewed. There was provision for recording drug allergy on the prescription card.

A select number of nursing records were examined as part of this inspection. An eclectic model of nursing was in use and care plans were reviewed weekly. Records were accurately dated, the time of entry should be recorded using the 24-hour clock and all entries should be signed in full with block lettering alongside the signature of the first entry. Generally, the records appeared to identify problems that had arisen and action taken by staff to rectify them. Records were written clearly and had entries relating to how patients settled into the ward at the end of their first day of hospitalisation. One record examined, noted that a patient had suicidal ideation and intent. This was recorded in the planned and intervention section of care and there was no follow-up on the nursing care plans. This was pointed out to the staff locally. There was a need for some cross-checking and referencing of clinical information in the nursing and medical clinical notes and it was suggested that some form of integrated file be introduced. Ideally, nursing records should reflect the involvement of patients in planning and making choices and decisions about their care and treatment and evaluations of nursing care plans should include patients' views on their progress.

To ascertain service user opinion on the level of service provided, three patients were interviewed. All were quite happy with the admitting procedures and were very pleased with their consultant psychiatrists and junior doctors. Two already had access to a social worker and both were very pleased with this intervention. Last year, the Inspectorate's perception was that nurse/patient relationships were diminishing. However, on this visit

of inspection such a perception would appear to have been unfounded. All patients were very pleased with the nurse/patient interaction. The nurses were found to be extremely helpful, co-operative and pro-active in patient approach. They also treated the patients with dignity and respect and afforded them the utmost privacy at all times. These three patients did not receive an information booklet on the hospital and neither were they aware of patient care plans. It was advisable that all pertinent information such as patients' rights, complaints procedures, information on medications, care plans, etc. should be included in the Hospital Handbook and a designated person should be assigned to ensure each patient obtained one.

RECOMMENDATIONS

It is recommended that:—

1. Discussions continue with the Area 3 service (Dublin South City) with a view to realigning catchment area boundaries.
2. The consultant posts in rehabilitation, liaison and the two general adult posts be filled in a permanent capacity.
3. Alternative and upgraded facilities be provided to replace St Kilian's Clondalkin.
4. Patients be relocated from Unit F to the new temporary unit at St Loman's Hospital.
5. The Aspen ward at AMINCH Hospital open as soon as possible.
6. A skill mix and skill substitution exercise be introduced to ensure optimum use of skill nursing resources in view of the ongoing staffing difficulties experienced by this service.
7. The bathrooms, toilets and safe rooms at AMINCH Hospital be upgraded.
8. A system of cross checking and referencing of documented clinical information recorded in nursing and medical records be introduced.
9. An annual review of the quality, efficiency and effectiveness of the service be included in an annual written report.
10. The Ballyfermot Mental Health Centre be redecorated externally and internal ventilation be improved.
11. Teach Bán the premises at Newcastle, Co Dublin be retained by the Mental Health Service and developed as a supervised community residence.

INSPECTED ON 9 OCTOBER, 2002

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 171,000 was divided into four sectors as follows:

Sector	Population
North Kildare	55,000
Mid-East Kildare	45,000
Mid-West Kildare	40,000
South Kildare	31,000

IN-PATIENT CARE

In-Patient care was provided at the thirty-bed Lakeview Unit of Naas General Hospital in one integrated ward.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	3	5	3	1	—	12	36.4
3 to 12 Months	—	—	3	3	2	—	8	24.2
1 to 5 Years	—	1	7	2	3	—	13	39.4
Over 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	4	15	8	6	—	33	100
% of Total	—	12.1	45.5	24.2	18.2	—	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	18	—	10	2	—
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
1	2	—	—	—	33

Status of In-Patients on the date of inspection 2002

Status	Male	Female	Total
Voluntary	10	6	16
Temporary	5	2	7
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	15	8	23

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
693	4.0	158	22.8	83.3	16.7	719	1

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of Persons Attending
Day Hospitals	3	36	310
Day Centres	2	22	N.A.
Out-patient clinics	15	604*	12.249

*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
3	16	1	6	2	30

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
15	8	80	2	10

COST

The cost of the Kildare Mental Health Service was €7.5 million in 2001.

GENERAL COMMENTS

All the sectors in this catchment area, except one, had identified sector headquarters and day facilities. The exception was the sector centred on Naas, the largest population centre in the service. It was regrettable that this sector had neither a sector headquarters nor a day hospital. It was vitally important that a premises was acquired for these purposes without delay. In the Kilcock sector there was a proposal to erect a sector headquarters in the grounds of Boycetown House, the current day facility. This was to be funded by the sale of Auburn House in Kilcock, which currently fulfilled this purpose, but did so inadequately. The day hospitals and sector headquarters in the generic health centres, newly established, at Athy and Celbridge, were reported to be functioning well and carrying out their purposes adequately.

The Inspectorate was heartened to learn that the acute unit at Naas General Hospital was now functioning well and that the ‘beds on the corridor’ syndrome, which characterised this service in recent years, had now disappeared. Since the beginning of 2002 the unit had fulfilled its purpose adequately within its bed complement of thirty. It was unfortunate

that the unit was currently continuously locked, but plans were afoot to provide an upgraded acute observation area, lockable if required, to enable the rest of the unit to remain open. The Inspectorate was very interested in this proposal, but felt that it needed, both from the design and operational points of view, careful planning and surveillance to ensure that it did not become a permanently locked facility within the unit itself. It was hoped that within the admittedly difficult design fabric of the unit, every initiative would be used to create an acute observation area that respected civil rights and was minimally restrictive. The Inspectorate will follow progress on this particular front with interest.

The unit had now been functioning for over ten years and, on the whole, had worn fairly well and functioned more or less adequately within the limitations of its less than satisfactory design. Certain upgrading was now necessary, particular instances being the unkempt courtyard garden, missing lavatory seats, and the need for a sympathetic refurbishment of the safe room. It was noted that activation and occupation for in-patients had been considered a priority and had now been strengthened by the allocation of two nurses to complement the full-time occupational therapist. With the extension of Naas Hospital and the considerable increase in beds, consideration should be given to setting up a more formal and specialised liaison service. Because of the general adequacy of services for older persons in the region, a specialised later-life psychiatry service was not perceived as a priority and, indeed, the establishment of an acute assessment sub-unit for the elderly within the fabric of the acute unit was difficult to perceive.

There was, apparently, a view that the West Wicklow part of the catchment area, particularly the upper part, around Blessington, would more appropriately be served by the Dublin South Western Area service, not least because of the fact that the main transport lines ran from that area directly to Tallaght, rather than to Naas.

There were now five consultants in post for the service, two of them on a temporary basis. The temporary posts were now being processed by Comhairle na nOspideal with a view to their permanent filling. There were ten non-consultant hospital doctors and one senior registrar, and the service was part of the Dublin University postgraduate psychiatric medical training programme. Nurse recruitment was apparently not a problem and there were few, if any, vacant posts. The psychology, social work and occupational therapy personnel needed strengthening to provide a truly multi-disciplinary team in all five sectors. Administratively, the service was managing well with good relationships and frequent meetings between the clinical professionals and administrators.

Ten patients were placed on one-nurse-to-one-patient special nursing supervision and there were 263 spans of special nursing supervision during 2001. There were eighty episodes of seclusion in this service in 2001, involving sixteen patients. From a check of the seclusion register, it appeared there were 165 episodes of seclusion in 2002 up to the date of inspection, with twenty episodes involving twelve patients during August and September. Some authorisations for seclusion were by junior doctors and some of the signatures were illegible. There was a need for all seclusion authorisations to be counter-signed by a consultant psychiatrist. Usually, seclusion authorisations were for twenty-four-hour periods, and in some cases the hours were not stated. There was a written policy and

procedure for the use of seclusion, dated 1998, which was under review at the time of this inspection. There was a system in place to document the observations of patients while in seclusion. This did not always contain the signature of the nurse and there were instances where the observations were not recorded. The signature in full of the nurse making the observations and a general description of the observations made should be recorded. The use of initials was not satisfactory. Hospital management should audit the use of seclusion and, where its use appears high, a reduction plan should be produced, including monitoring the effect of any change in management regimes on the attitude and behaviour of patients. Similar attention should be paid to the documentation of observations, as some records examined were cramped and illegible or simply failed to record that reviews were being carried out. All entries in the register should be clear and the grounds for seclusion clearly stated. There was reasonable privacy for patients while in seclusion and the room furnishings were appropriate for that purpose. This room was used at times as an additional bedroom when the ward was at full occupancy. As the room appeared to be purposely designed for seclusion, its use as an ordinary bedroom was not satisfactory.

The facilities for ECT were satisfactory. There was a draft policy on ECT and a named consultant psychiatrist responsible for the ECT clinic and the induction process for new doctors. The consent form in use was satisfactory and there was a pre- and post-ECT nursing checklist which was completed satisfactorily. One nurse was assigned direct responsibility for ECT and for the monitoring of the administration of Clozaril. This nurse was trained in basic life-support procedures. There were four CPR instructors employed in this service.

Thirty patients took their own discharge from the service against medical advice in 2001. All patients were offered out-patient appointments if deemed clinically appropriate. There were 116 involuntary admissions to this service in 2001 and twelve patients admitted involuntarily were regraded to voluntary status during the course of their hospitalisation. An involuntary admission rate of 17.3 per cent was rather high and required review. Detailed statistical records should be kept of the number of extensions of involuntary admission orders, as the information was not readily available to the Inspectorate during the course of this inspection. Twelve patients were transferred from the Lakeview unit to Dublin hospitals in 2001. The Inspectorate was pleased to note that this practice had stopped, with the opening of additional residential facilities within the county. There was one death in the unit in 2001 (by suicide). All safety procedures were reviewed following the incident.

There were 120 recorded accidents to patients, sixty involving minor injury and sixty involving no injury. There were nine recorded accidents to staff, all involving minor injury. As the number of accidents to patients had increased from forty in 2000 to 120 in 2001, there was a need to audit all of the accidents in order to enable tracking and trending of information so as to promote improved management of identified risks. There were fifteen recorded assaults on patients by other patients which did not cause any detectable injury and there were a further fifteen assaults on staff, resulting in minor injury — scratches, bruising, etc.

There were no research projects undertaken in this service governed by the Clinical Trials Act 1987 — 1990. There were two recorded complaints and two requests under the Freedom of Information Act made to the local complaints manager in 2001. All appeared to have been dealt with satisfactorily. A written complaints policy and procedure should be available and displayed on the unit and brought to the attention of patients. While there was a notice informing patients of their rights, there was some doubt as to whether this was brought to the attention of patients. Service providers should ensure that information given to patients about their legal position and rights under the Mental Treatment Act, 1945 was appropriately recorded in the patients' case notes. Experience shows that where patients did not understand their legal position and rights this was often the result of not providing appropriate communication at an appropriate level and checking that this information had been understood. It was not possible by reference to the patients' case notes to identify when and by whom an individual patient's rights were explained, particularly to detained patients. It was recognised that there were difficulties in explaining legal matters to patients whose mental state might preclude the understanding or retention of such information. While services were sensitive to the capacity of each individual patient and rights were explained as far as possible in a way the patient understood, it should be recorded in the notes, with 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 written policy for the ordering, prescribing, storing and administering of medicinal products was under review. The standard of prescription writing was quite variable; some prescription cards were signed and dated individually; in others, the signature of the prescriber was illegible. Some had one date and signature for a group of prescriptions, and the discontinuation column on a number of cards examined was not signed and dated. The system of drawing a line through a prescribed medicinal product and not signing or dating the discontinuation column was not satisfactory. There was an increased risk factor of drug error in a considerable number of cards where discontinued prescriptions were greater in number than current prescriptions. All of these cards required rewriting. The drug administration recording card should have provision for the nurse's signature in full. All of this was referred to in the general comments on the report for this service for the year 2001.

Previous reports commented on the extensive consultant-led liaison psychiatry service to the A & E Department of Naas General Hospital. There was a need to keep statistical data relating to all liaison consultations and outcomes, whether admitted to the psychiatric unit, referred to out-patient care, or referred to other services.

All staff appeared aware of the importance of approved policies, procedures and protocols. At the time of this inspection, all policies procedures and protocols were under review and draft documentation had been produced. Revised draft policy and procedure statements had a note on date developed and by whom, date of approval, date effective, and a review date. The scope of the policies and similar documentation applied to all staff with responsibility for the care of patients. The policy, procedures and protocols under review should not refer to patients as 'clients'. They are patients as defined under the

Mental Treatment Act, 1945, as amended. Once the new policies and procedures become effective, a computerised index of all policy documentation should be kept, with an up-to-date, unit-centred file of all current policies. Revised and superseded policies should be removed from operation and a pre-determined number should be retained centrally for possible reference in future. Revised and updated policies should be formally introduced to relevant staff, ensuring an awareness and understanding of content. Staff should sign that they have read, understood and intend to and are able to comply with the policy and procedure content.

Newly admitted patients to the Lakeview unit had a full medical evaluation, including comprehensive admission notes, mental state examination, physical examination and clear immediate management plan documented in their clinical files. All entries in the clinical files should contain the signature in full and designation of the person making the entry. Written instructions of filing of documentation within the record was required. While there was provision for the recording of the patient's name on each continuation page, this was not always done. Ideally, the professional staff member 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 patient's name and record number were not always noted on each continuation sheet. The storage of loose clinical material within the files required review. Risks associated with the storage of this material included delay in accessing pertinent information and lost or misfiled relevant clinical information.

The management team of this service met on a monthly basis and there were regular meetings with the assistant chief executive officer of the health board. All of this was new and welcomed. The fire and safety committees for the hospital as a whole met on a monthly basis and the Lakeview unit was integrated into these committees. While there was a formal induction process for staff, there was a need to keep records of the process, with the names of the person conducting the induction, content of programme, and the names of staff inducted. All health and safety statements in this hospital were reviewed and updated in August 2001. The fire officer visited the service regularly. There was a need to keep records of fire drills in the unit and records of evacuation drills in the community residences.

Access to fresh air, which is a basic human need, was taken seriously by hospital service providers. Although the unit was locked due to building work, patients had unrestricted access to an enclosed garden, which was originally attractively landscaped but had not been well maintained. Greater attention was required to ensure that this internal garden was maintained up to a satisfactory standard.

The nursing record comprised historical and personal data, assessment details and patient care plan. The nurse completing the patient assessment and the care plan should sign each entry. Ideally, the name of the patient's primary nurse should be entered in the nursing record. Records examined had entries relating to how patients settled into the ward at the end of their first day of hospitalisation. Entries were generally made as soon as possible after the events to which they related. While all entries were accurately dated, the time, using the 24-hour clock, should also be recorded. The patient's name was accurately

recorded on each continuation page. As abbreviations were used extensively in the notes examined, there was a need for a written policy on the use of abbreviations. Nursing records should be written so that they were readable on photocopies. Ideally, the 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 plans should include patients' views about progress.

Three patients were interviewed to assess their opinion of the services provided. One patient, obviously because of the nature of the illness, was extremely critical of all aspects of the service and such views could not be accepted as fair or accurate comment. One point, though, made by this patient should be recorded and that was that the secure room should not be part of any acute psychiatric unit at a general hospital and should be replaced by special nursing. This patient had sufficient insight to realise that self-harming behaviour in this case did indeed necessitate special containment measures. This patient also expressed the view that having the final main meal of the day at 4.30 p.m. was far too early. This patient was not of voluntary status and expressed the wish to become voluntary, as had been the case on a number of previous admissions. The Inspectorate arranged that this request be passed on to the relevant consultant psychiatrist.

The other two patients, one of temporary status and the other of voluntary status, were much more positive in their assessment of the services. Both were well acquainted with their consultant psychiatrists and their primary nurses and were very pleased with the frequency of their consultations with them. They knew the nature of their illnesses and their prescribed medications and side effects the latter could cause. One patient was not allowed wear his own clothes for some two weeks after admission. The reason for this was not explained, but the patient assumed such practice was to prevent patients absconding. No patient was given any information about the hospital and neither were they informed of their rights under the mental treatment legislation or of the procedure involved should they wish to register a complaint. They found the quality of the food provided was excellent and they were also pleased with the overall ambience of the unit, décor, hygiene, toilet facilities, etc. They were also pleased with the dignity and privacy afforded them. When asked how the services could be improved, they made the following suggestions:

- There should be more frequent opportunities to get off the wards by organised outings, trips up town, etc.
- There should be more varied therapeutic and social activities on the ward as the evenings and weekends could be quite boring.
- There should be better facilities for visitors and the provision of a coffee dock was emphasised.

RECOMMENDATIONS

It is recommended that:—

1. A sector headquarters and day hospital be provided in Naas for that sector.
2. A multi-disciplinary specialist rehabilitation team be recruited for this service.

- 3. Consideration be given to the putting in place of a liaison and, at a later date, a specialised service for older persons.
- 4. The Clonree and Castledermot premises be brought into operation to provide additional community residential places.

NORTHERN AREA HEALTH BOARD

**PSYCHIATRIC UNIT, JAMES CONNOLLY MEMORIAL HOSPITAL
CATCHMENT AREA 6 — 2002 INSPECTION**

INSPECTED ON 27 NOVEMBER, 2002

GENERAL DESCRIPTION OF THE SERVICE

The population of the catchment area was 63,000.

Sector	Population
Blanchardstown (A & B)	63,000

IN-PATIENT CARE

In-Patient care for the Blanchardstown sector was provided at the twenty-two bed integrated unit (Unit 9) at James Connolly Memorial Hospital (JCMH).

Age and Length of Stay of all Patients at 31.12.01

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	1	8	4	—	—	13	86.7
3-12 Months	—	—	—	—	1	—	1	6.7
1-5 Years	—	—	—	1	—	—	1	6.7
> 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	1	8	5	1	—	15	100
% of Total	—	6.7	53.3	33.3	6.7	—	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	3	—	8	3	—
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
—	1	—	—	—	15

Status of In-Patients on the date of inspection 2002

Status	Male	Female	Total
Voluntary	15	26	41
Temporary	5	2	7
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	20	28	48

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
302	4.8	107	35.4	94.4	5.6	310	0

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	10	63
Day Centres	2	70	90
Out-patient clinics	7	597*	1,812

*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
3	34	3	24	4	67

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
17	13	59.5	25.7	8.4

COST

The cost of the Area 6 Mental Health Service was €6.7 million in 2001.

GENERAL COMMENTS

The newly built psychiatric unit for this service consisted of fifty-six beds, six of which were for acute assessment of older persons by the psychiatry of later life service, and which incorporated a day hospital for that service, had now been handed over to the service. It would replace the thoroughly unsatisfactory present admission unit, Unit 9, on James Connolly Hospital site. Unlike the existing Unit 9, which served the two Blanchardstown sectors of the catchment area, the new unit would serve all four; both Blanchardstown sectors, Finglas and Cabra. Currently, these latter two sectors were served for acute admission purposes by two units in St Brendan's Hospital. These two units in St Brendan's (3A & 3B) were unsuitable for acute admission purposes as was the existing unit in Blanchardstown and it was certainly felt by the Inspectorate that, when the new fifty-six bedded Blanchardstown unit would open, the St Brendan's admission units should close.

Three management teams from St Brendan's, Area 6 and James Connolly Memorial Hospital formed themselves into a steering committee to oversee the transition to the new unit. This had occurred quite recently and the steering committee had formed no less than twenty-two working groups to work on each specific element involved in setting up the new unit. The overall steering committee met every three weeks to follow progress and discuss the group's recommendations. Aspirations were that it would be receiving acute admission patients from the closed Unit 9 and the closed admission units in St Brendan's by mid-2003. However, the Inspectorate had some reservations about this timescale.

The new day hospital for the elderly incorporated in the new James Connolly Memorial Hospital acute unit will only accept patients of the Later Life Service. Out-patients who came to the existing activation/occupational unit will be relocated to a separate facility. Unit 3 in James Connolly Memorial Hospital provided continuing care for the later life service, designated under the Mental Treatment Act, 1945. This unit was located on land that had been sold for development purposes and would be replaced by a refurbished unit at James Connolly Memorial Hospital, which would form part of the overall elderly care services on the James Connolly Memorial Hospital campus. Unit 10 in James Connolly Memorial Hospital, formerly a continuing care unit for the general adult psychiatric service of St Brendan's Hospital, had been closed since the last inspection.

On the community side, there had been a number of initiatives and developments. In Finglas, there were now two consultant-led teams operating, although the sector itself had not yet been sub-sectorised and continued to operate as one unit. The day facility, which operated in the sector at North Road was of poor quality, and was to be closed and replaced by a new facility at the Century Business Park at Finglas. It was expected that this would happen in the coming months. The Inspectorate would like to see the new premises operate an acute day hospital service and awaits developments here with considerable interest.

In the Cabra Sector the main community base for day activity was in Conolly Norman House. Last year's Inspector's Report highlighted the unsatisfactory and confusing nature of the multi-purpose function of this establishment and pleaded for a more rationalised and clearly delineated function for the building. In particular, it was advocated that the out-patient service provided by Area 7 from this building be re-located to its own premises in 62/63 Eccles Street, which, at that time, was being upgraded. It was understood that this upgrading had been completed but there was some uncertainty as to whether the out-patients for the Mater sector of Area 7 could be accommodated in Eccles Street. It was the Inspectorate's view that this should be the case and should be instigated as a matter of urgency. This would relieve overcrowding and put an end to the Area 7 catchment area teams operating from Conolly Norman House. A number of activities unique to Area 6 services were still being provided from Conolly Norman House, such as day hospital out-patient administrative offices, etc. It was the Inspectorate's belief that, at the least, out-patient services should be provided from a primary health care structure rather than from a secondary care premises. Adelphi House, North Circular Road a large fifteen-place high-support community residence had undergone minor upgrading since the last visit of inspection. It was felt that further upgrading, particularly in the roof area, and re-decoration and furnishing was essential to bring this premises up to an acceptable standard of decoration and presentation.

In the Blanchardstown sectors the Inspectorate visited the premises leased by the health board in the Techport Business Park in Coolmine. This building, while unfurnished and requiring some structural input on the ground floor, would serve as a sector headquarters for the two Blanchardstown sectors, with the administrative offices based on the first floor and patient accommodation, largely of a day hospital nature, on the ground floor. It was hoped the office space would be used prudently and judiciously with space being allocated to the multi-disciplinary sector teams without individual designation. This would ensure that valuable space was used efficiently, and would not result in the common practice of offices designated to individuals being occupied for only a few hours per week. It was also the Inspectorate's view that, in the patient area, premises sufficiently large and unintimidating be provided to accommodate disturbed and restless patients in order that these premises could function as an acute day hospital. The sector headquarters component of these new premises would enable The Lodge, currently used to accommodate staff on the James Connolly Memorial Hospital site, to be vacated. This long overdue development was very much welcomed.

The Northern Area Health Board had also acquired a new house at Church Avenue, Blanchardstown which was to serve as a medium-support community residence. It was being upgraded to conform to fire and health and safety requirements. Fingal County Council had agreed to exchange the current house in Drumheath, a medium-support residence that was the target of constant vandalism, for two adjoining houses in a new council development at Castlecarragh. It would increase the provision of low-support residential accommodation in the area. Two low-support residences at 226 and 228 North Circular Road were at this time the subject of re-painting and decoration.

It was hoped to establish a consultant-led multi-disciplinary rehabilitation team for the service and, similarly, an additional consultant-led team for the later life psychiatry service,

which currently straddled two catchment areas, Areas 6 and 7. Indeed, an application had been made by the Eastern Regional Health Authority to establish this post but the matter had been slow to progress; on a purely population base of elderly in the two catchment areas it would seem justified. It was encouraging to hear that the service was committed to a community outreach, crisis intervention approach to its work. An additional specialisation that required consideration was that of liaison psychiatry to the Accident and Emergency Department and general wards of the expanding James Connolly Memorial Hospital. There was a dearth of multi-disciplinary staff with only two social workers and 0.4 psychologists working in the service.

There was a written policy for the ordering, prescribing, storing and administration of all medicines, which had recently been reviewed. A new prescription cardex was introduced since the last visit of inspection. The legibility of individual prescriptions examined at Unit 9 was of a very high standard. There was a low risk factor of drug administration error as all prescriptions were in block writing. Prescriptions should be dated and signed individually and the full signature of the prescriber should be used. The drug administration recording card had provision for the nurse's signature in full, which was satisfactory.

Seclusion was not used at Unit 9 and the service continued to experience some difficulties in managing patients who exhibited disturbed behaviour. Staff also reported difficulty in accessing beds in the special care unit at St Brendan's Hospital. Special one-to-one nursing supervision was used in James Connolly Memorial Hospital and there were 1,073 spans of special nursing involving twenty-nine patients in 2001. Seventeen patients were admitted on temporary admission orders and no patients had their temporary admission orders extended during the year. There were ten recorded complaints made to the local Complaints Appeals Manager during the year and all appeared to have been dealt with satisfactorily. There were thirty-seven recorded accidents to patients and five recorded accidents to staff during the year. Five of the patients' accidents resulted in minor injury and one of the staff accidents required further medical intervention. There were seventy-two recorded assaults at James Connolly Memorial Hospital, with seventy-one on staff members and one on a patient by another patient. The patient assault and three of the staff assaults resulted in minor injuries, scratch, bruising, etc. and one of the staff assaults was deemed serious. A total of twenty-one patients were prescribed ECT during the year and documentary procedures relating to ECT were all satisfactory.

From an examination of clinical files, each newly admitted patient had a full medical evaluation, including comprehensive admission notes, mental state examination, physical examination and a clear immediate management plan documented in all notes examined. Some of the signatures following inputs in the clinical notes were illegible. Ideally, the professional making an entry in clinical notes should print their name after their first signature and their designation within the clinical team should be clearly stated. Whilst there was provision for the recording of a patient's name on each continuation page, this was not always recorded. Written instructions on filing of documentation within the clinical records was required. Copies of discharge summaries, which were sent to the GP responsible for the patient's follow-up post-discharge, were available in the clinical files.

A new discharge planning checklist was under active consideration and would be introduced in the new admission unit scheduled to open next year.

There was a patient information leaflet setting out general information for all patients at James Connolly Memorial Hospital. A more specific information leaflet was required for the mental health service setting out pertinent requirements for the unit and informing patients of their statutory legal rights under the Mental Treatment Act, 1945 and amending legislation. This should be considered for the new acute psychiatric unit. 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. Whilst the rights of detained patients were prominently displayed in the in-patient care area, they should be included in a hospital brochure. Informing patients of their rights involved two tasks; the first, to provide a written explanation via the patients' notice boards or hospital leaflets, the second, was to be satisfied that the patient understood his or her rights. As soon as practicable after admission, patients should be informed of their rights. This information should be given in writing by handing the appropriate patients' rights leaflet to the patient with a verbal explanation of its content. An entry should be made in the patient's nursing documentation that an oral and written explanation had been given with an indication of the patient's understanding. If the patient was incapable of understanding, this should be recorded and the information should be repeated at regular intervals using professional judgement deciding on the patient's capacity for understanding. Similarly, whilst there was a complaints policy and procedure at James Connolly Memorial Hospital, a system needed to be introduced to ensure that this information was readily available to patients.

Patients at James Connolly Memorial Hospital, Unit 9 did not have easy access to a shop because of its geographical location on the hospital campus. This should change with the opening of the new unit.

The hospital had a policy on patients absent without official leave. This was reviewed and updated in 2001. All staff worked in accordance with hospital policy in relation to absence without official leave. The policy highlighted immediate action when a patient was missing. When next reviewed, this policy should clearly state who had responsibility for returning patients, who should take charge of the absent without official leave procedure, when a search should be initiated, by whom and who should take charge of the search procedure, when the Gardaí should be informed, when the nearest relatives should be informed, when the health board should be informed and the name of the person with responsibility for carrying out these tasks. A missing patient procedure checklist should also be introduced.

All policies, procedures and guidelines were under review in the context of re-location of services to the new acute in-patient unit. Policies, procedures and guidelines were generally required for each process where there could be variability in the processes that could affect the quality of care or services to a patient. A policy should be generally considered to be a statement of intent on a given issue. A policy should describe who was involved in the implementation of the policy and the planned revision dates. A procedure should

generally outline the actions to be taken to implement a policy. It should be a detailed framework that instructed on the required practice. A guideline, may be less prescriptive than a procedure, but should be in line with the organisation's policies and be developed using professional judgement and decision-making. Generally, staff appeared aware of the importance of approved policies, procedures and guidelines in reducing the level of clinical risk. Ideally, in order to reduce risk, each policy, procedure and guideline should have a true multi-disciplinary focus where appropriate, be headed by a unit title, be individually numbered, the author noted, the date of ratification recorded and by whom indicated. Each should have a review by date and responsibility for this should be detailed. Once policies are reviewed and updated, they should be formally introduced to relevant staff ensuring awareness and understanding of content. Relevant training and education should be given if policy content affects current practices. Staff should sign to say that they have read, understood and intend to, and are able to comply with all policy, procedure and guideline content. There should be a regular review of policy, procedure and guideline validity. Systems should be developed to retain superseded or obsolete policies and ensure revised and updated ones are centrally ratified, referenced, dated, systematically implemented and compliance audited. It was recognised that the drawing of policy documentation relevant to a new acute psychiatric unit is an onerous task and difficult to achieve. It is also an exciting challenge to establish a detailed risk profile for the unit and an opportunity to evaluate the effectiveness of existing risk management activity and make prioritised recommendations on methods of implementing effective in-house risk management processes.

Nursing records examined had inputs relating to how a patient settled into the ward at the end of their first day of hospitalisation. Records appeared to identify problems that had arisen and outlined action taken by staff to rectify them. All records were written clearly. All were accurately dated and signed. Time of entry was recorded, using the 24-hour clock, which was very satisfactory. The patient's name was recorded on each continuation page. A new nurse care planning system was about to be introduced next year to coincide with the opening of the new acute psychiatric unit. Revised nursing records should have provision for recording the name of the patient's primary nurse and the records 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' own views about progress.

The management team of this service met on a regular basis and minutes of management meetings were kept. There was adequate training for staff on fire awareness and fire prevention. Safety statements were reviewed in 2001 and a generic hospital and site-specific safety statement was available in each unit. Similarly, copies of recent safety audits were available for inspection. The system for reporting and documenting of accidents, incidents and assaults was all under review at the time of inspection.

Three patients were interviewed to assess their opinion of the services provided to them. In order to attain consistency from the various services throughout the country, each interview covered some sixty-five topics. In view of the fact that one patient here gave a negative opinion on all sixty-five topics, it was quite obvious that the patient's mental

condition coloured all replies and, consequently, they were discounted and the opinions given by the other two patients interviewed were relied on.

Both patients had previous admissions to this unit; for one, this was the tenth admission and for the other, it was the second and the duration of the present hospitalisation was two weeks and three weeks respectively. Both were of voluntary status. They were very pleased with the admitting procedures and with the privacy, dignity and courtesy afforded them. They were quite satisfied with the frequency and duration of the medical and nursing consultations and said the medical and nursing staff were always available when needed. Following admission, one patient remained in night attire for a short time and the reason for this was explained to and fully accepted by the patient. They had a reasonable input into decisions made about their care but neither ever heard about a patient care plan. Neither was aware of their rights under the mental treatment legislation nor were they aware of any complaints procedures. Both were quite pleased with the way their illnesses and treatment regimes were explained to them. They felt they received reasonable explanations about their medications and possible side effects but both affirmed they would like written information in layman's language. The concept of a primary nurse was not understood by them. They were quite satisfied with the general ambience of the unit, the décor, hygiene, heating, quality and quantity of food, etc. but they had some reservations about the toilet facilities. They were satisfied also with the therapeutic, recreational and social activities provided but one patient would prefer if there was greater access to outdoor pursuits. Neither patient had had access to either a social worker or a psychologist but they had not requested such access and felt that, if they had, it would be readily forthcoming.

When asked how the quality of the services could be improved, one suggested that a domestic-type washing machine and clothes dryer would be appreciated, while the other suggested that a small tea and/or coffee dock would be of great value.

Some time after the interview with these patients was concluded, one of the patients approached to make it known he wished to commend the ward sister "for all she had done for the patients".

RECOMMENDATIONS

It is recommended that:—

1. All the preliminaries to opening the new acute fifty-six bedded psychiatric unit in James Connolly Memorial Hospital be proceeded with all speed.
2. Once this unit opens, Unit 9, James Connolly Memorial Hospital and the two admission units in St Brendan's should immediately close.
3. Those long-stay patients currently occupying acute beds, approximately thirteen in St Brendan's and seven in Unit 9, be transferred to appropriate community residential care.
4. The local management team review the use of Conolly Norman House with a view to some rationalisation of service provided there.

5. Adelphi House be re-furnished and re-decorated.
6. Access to physiotherapy and occupational therapy be provided for patients in Unit 3, JCMH.

ST BRENDAN’S HOSPITAL — 2002 INSPECTION

INSPECTED ON 26 & 27 NOVEMBER, 2002

GENERAL DESCRIPTION OF THE SERVICE

The population of the catchment area was 65,788, and it was divided into two sectors as follows:—

Sector	Population
Cabra	22,782
Finglas	43,006

IN-PATIENT CARE

In-Patient care was provided at St Brendan’s Hospital where 171 beds were provided in six male and four female units.

Age and Length of Stay of all Patients at 31.12.01

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	2	16	18	8	5	49	30.63
3-12 Months	—	1	9	7	1	1	19	11.88
1-5 Years	—	—	13	31	6	1	51	31.87
> 5 Years	—	—	5	29	6	1	41	25.62
All Lengths of Stay	—	3	43	85	21	8	160	100
% of Total	—	1.88	26.88	53.12	13.12	5.0	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
1	99	5	18	10	1
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
4	9	—	13	—	160

Status of In-Patients on the date of inspection 2002

Status	Male	Female	Total
Voluntary	45	41	86
Temporary	39	17	56
P.U.M.	1	—	1
Ward of Court	3	—	3
Total	88	58	146

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
668	10.2	179	26.8	82	18	673	3

*Per 1,000 population

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	—	—	5	59

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
12.64	18.62	252	79	11

COST

The cost of the St Brendan’s Hospital component of the service was €25 million in 2001.

GENERAL COMMENTS

St Brendan’s Hospital performed a number of disparate functions, on the basis of pragmatic need and as a matter of history rather than flowing from a basis of rational planning, provision and clearly defined objectives. However, at this late stage in its history and when the number of resident patients had declined from 2,000 to approximately 150, a focused plan as to its future was being put in place. This was happening with the realisation that most of the existing buildings on campus would pass from the Eastern Regional Health Authority and its Northern Area Health Board to the Dublin Institute of Technology in the near future.

St Brendan’s provided acute admission beds for two sectors, Cabra and Finglas, of the Dublin North-Western psychiatric service (Area 6). The provision was through two wards in the admission block, 3A and 3B, one male and one female, with a total capacity of

approximately fifty beds. However, less than ten of these beds were used for acute purposes, with the remaining forty or so blocked by long-stay patients. Before the new admission unit in James Connolly Memorial Hospital for Dublin North-West (Area 6) psychiatric service became operational, and this was to be within the coming months, the admission function of these two St Brendan's units would transfer to James Connolly Memorial Hospital and they would close for admission purposes. The issue of where the long-stay patients currently in Units 3A and 3B would be accommodated was as yet unresolved. St Brendan's also provided intensive care functions through four wards. Originally, this special care unit of four wards was intended to provide for the entire former Eastern Health Board area catering, mainly on a short-term basis, or so it was intended, for difficult to manage and seriously aggressive patients. Of the numbers in this special care unit, which fluctuated between thirty-five and forty, approximately only sixteen required special care in the sense that this concept was usually understood. The remainder of patients, many of whom were long-stay, were in need of active rehabilitation rather than special care. The remaining category of patient catered for in St Brendan's was long-stay, including twelve in a residential unit for the homeless. St Brendan's had and continued to deal with transient and homeless persons, including those who arrived in Dublin from other jurisdictions by boat or aeroplane. The assessment unit, with its overnight beds, had been closed since the last visit of inspection and the premises was being re-decorated and refurbished to serve as an on-call doctors' residence and for office purposes.

A detailed placement assessment had been made on every St Brendan's resident, excluding the short-stay admission patients, constituting over 120 of the 150 in-patients. This had led to the following conclusions. Sixteen or so patients in need of special care could be taken care of if the three special care units which the Department of Health and Children intended to provide for each of the three ERHA health boards became operational. These Units would have fifteen beds in each with approximately twenty beds (fifteen male, five female) provided for the Northern Area Health Board. These three special care units would provide for all existing and all future special care need. Should the remaining long-stay patients be deemed suitable for conventional high-support accommodation when it became available, this would leave eighty to ninety difficult to place patients, deemed to need rehabilitation appropriate to their particular needs. The model considered as best meeting these needs was called "core and cluster". This would consist of a core home for eight residents with an adjoining rehabilitation unit, with the complex being completed by two small flatlets. This provision would cater for twenty patients and it was envisaged that, to deal with the existing number of such patients in St Brendan's, four to five of these "core and cluster" units would be required. In regard to the residences of origin, of these eighty to ninety difficult to place patients, it was suggested that one unit should cater for Area 6 and one for St Brendan's Hospital, one for St Vincent's, Fairview, one for Vergemount and one to serve the homeless as part of an extended and comprehensive service for that group. In relation to all of this there was recognition that the provision of additional community residences run by voluntary agencies could be required in addition to a rehabilitation and homeless outreach service. It was considered essential that two full-time rehabilitation consultant-led teams would be available to bring about the evolution and ultimate closure of St Brendan's as outlined above.

This was the plan that, in its essence, had been worked out for the closure of St Brendan's as alternative approaches to its current functions. The Inspectorate was impressed and approving of what was proposed and recommended that the necessary resources to make it all possible be made available. Already, a liaison team was working with the DIT having been set up by St Brendan's to plan further developments on the campus.

The current deficiencies in the St Brendan's service provision, which have been pointed out in the body of this report, need to be repeated here. Some of the community residences were in poor condition and needed either extensive refurbishment or replacement. Conditions generally in all wards of St Brendan's Hospital were poor, even though they had improved considerably in recent months. Two admission wards, 3A and 3B and one of the male special care units, in particular, provided poor, inadequate and unsatisfactory accommodation, both in the basic physical sense for patients and staff and were also quite unsuited to their therapeutic responsibilities. The lack of rehabilitation, adequate occupational therapy, social work and psychological services had also been highlighted.

Three patients in the admission unit were interviewed to assess their opinion of the psychiatric services provided them. One patient of voluntary status was on first admission and had only seven days' experience of the service. The other two patients had a number of previous admissions and the present period of hospitalisation for one was some ten weeks while, for the other, it was approximately three years. All patients were quite complimentary in their comments about the inputs from doctors and nurses. The patients found them to be extremely helpful and accommodating and always treated them with courtesy, dignity and understanding. The general ambience of the unit was very acceptable to the patients and they volunteered very little by way of complaints. On questioning, it transpired that they were given very little information about their psychological problems or about their medications and their efficacy, side effects, etc. Neither were they aware of their rights under the mental treatment legislation or about hospital procedures for making complaints, etc. They did not receive any booklet outlining information about the workings of the hospital and it was advisable that such a booklet should contain information on ordinary psychiatric illnesses, with ample information about medications, their side effects presented in easily understood language. Neither had the patients heard about care plans for patients nor were they ever involved in plans pertaining to their own care. They did state that they would indeed like to be so involved. All patients agreed that evenings and week-ends tended to be boring from want of therapeutic activities but they all agreed they had no specific ideas as to what activities they would like to see instituted. Their general opinion as to the general ambience of the unit was quite positive. The heating, décor, hygiene, toilet facilities, quality and quantity of food etc. were quite acceptable although one patient, while quite pleased with the quality of food, would like to see the quantity increased. The concept of a primary nurse was also not known to these patients.

Patients were rather reticent regarding suggestions for the improvement of the service.

In summary, however they suggested that the following matters would be appreciated.

1. Written information on psychological illnesses, medications, side effects, etc. should be supplied to each patient.
2. More therapeutic and social activities should be available, especially at evenings and weekends.
3. The quantity of food should be improved at mealtimes.

A new nursing care plan, using the 'Orem' human needs model had been introduced to parts of St Brendan's since the last visit of inspection. This nursing component comprised a dedicated booklet with historical and personal data assessment details and self-care needs, goals and nursing notes section. The standard of completion of nursing documentation was quite variable. In some wards, the biographical data was not completed and, in others, the quality of content was variable. Not all sections were completed in all areas examined. No record was made as to the reason for this. All entries were signed and dated. The quality of documentation within the self-care needs and goals sections was also of variable quality. It appeared, from the documentation, that the needs and goals were predominantly nurse rather than patient oriented. Some involvement of the patients and some record that the patients themselves acknowledged the problems and were willing to assist in the actions determined should be incorporated into the care plan, though it was recognized that not all patients would be able to participate fully in this process. Progress reports as distinct from nursing care plans were recorded in the community residences. These were written up each Sunday and required the full signature and designation of the staff member making the entry. The nurse should sign the self-care needs and goals form. Generally speaking, the new nursing care plans examined at Unit O were of a satisfactory standard. In relation to one patient in the admission unit, admitted three days previously, there were three entries in the nursing notes. No care plan had been completed and the biographical data was not completed and there was no explanation for this. In another note examined, the self-care needs and goals were not completed in one instance, although the nursing assessment had been entered. Staff had reverted to the use of ward progress notes. Nursing records should be audited to assess standard of record and identify areas for improvement and staff development.

No written drugs policy and procedure was available in the clinical areas for inspection. Individual prescription cards were of a variable standard in relation to legibility. All prescriptions were dated individually and all had been reviewed and updated since the previous inspection. A small number of prescriptions required the signature in full of the prescriber. All drugs discontinued were signed off using the discontinuation column with a date and signature. An increased risk factor of drug error was noted on a number of prescription cards where discontinued prescriptions were greater in number than current prescriptions. These cards should be re-written. The storage area and the transport system for medicinal products was satisfactory. User-friendly written information on medication treatment should be made readily available to all patients and relatives. The drug prescription and recording cards had provision for the recording of drug allergies or drug sensitivities so that information was rapidly available to staff. On a number of cards, this was not

completed and no reason was stated. If there were no known drug allergies or drug sensitivities, this should be recorded. 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 a clear immediate management plan appropriately recorded in all notes. There were written instructions on filing of documentation dated 1994, which should be reviewed and updated. The patient's name should be clearly recorded on each continuation page of the medical notes. As commented in reports of previous years, there was a considerable collection of loose clinical material in the back pocket of all files examined. This needed to be reviewed as the contents were not secure and there were delays in accessing pertinent information and dangers associated with lost and misfiled clinical information.

Generally, staff appeared aware of the importance of approved policies, procedures and protocols in reducing the level of risk. At the time of inspection, it was reported that all policies and procedures were under review. From a risk perspective, it was necessary to have systems of implementation and audit of compliance to enable risk reduction or elimination to occur. The Inspectorate was informed that the multi-disciplinary committee had drawn up a list of policy documentation relevant to the service and it was accepted that this was an onerous and difficult task. Ideally, all new policies should have a multi-disciplinary focus where appropriate, be headed with a hospital title, be individually numbered for ease of reference and filing, note the author, record date of ratification and have a review and audit by date and detail responsibility for these. A computerised index of all policy documentation should be kept and there should be a central file of all current policies with a named person identified with the responsibility for ensuring the file is updated. Revised and superseded policies and procedures should be removed from operation and a pre-determined number of copies should be retained centrally for possible reference in the future. Policies, procedures or similar documentation, once reviewed, should be formally introduced to relevant staff, ensuring awareness and understanding of content. There should be regular reviews of policy validity. This could be incorporated into an audit process to enable assessment of efficacy and compliance. Guidance on the management of illicit drug use or drug-related incidents, setting out action to be taken if suspicion of illicit drug use or supply, policy for staff to search and confiscate illicit drugs or alcohol or dangerous weapons and arrangements with Gardaí regarding disposal of illicit drugs or dangerous articles confiscated should be included in the revised and updated policies and procedure manual. A revised policy and procedure should be developed, relating to patients absent from the hospital without official leave indicating the responsibility of the service to return the patient, naming the person to take charge of the local search procedure, the person to contact the Gardaí and when and whom contacts the patient's relatives. This should be available in each area for staff information and reference.

The patient's money management system was satisfactory but some system should be in place to inform patients of hospital charges. The service providers should ensure that a system of verification is in place, using a standardised form to record that information is given to patients about their legal position and rights under the Mental Treatment Act,

1945. The giving of information on rights, particularly to detained patients, should be adequately recorded in the patient's case notes.

There were 116 involuntary admissions to St Brendan's Hospital last year. Seventeen patients admitted as involuntary patients were re-graded to voluntary status during the course of their hospitalisation. Sixteen patients admitted as voluntary patients were re-graded to involuntary during their hospital stay. There were 102 extensions of involuntary admission forms during 2001. Extensions of involuntary admission forms were recorded in the clinical notes. Nevertheless, there was a need to ensure that the detention of each patient was kept under constant review by the clinical team. Decisions on the continuation of detention should be based upon clinical need. The service providers appeared to have adequate flagging systems to record and trigger specific actions ensuring compliance with the regulations under the Mental Treatment Act, 1945. Two patients were transferred from St Brendan's under Section 208 of the Mental Treatment Act, 1945 to the Central Mental Hospital in 2001. Of the 673 discharges from St Brendan's, forty-four 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. Ninety-three patients were discharged from St Brendan's to other approved mental health centres, nine to Tal-laght, thirteen to James Connolly Memorial Hospital, eight to St James's, eight to St Patrick's, ten to St Vincent's Hospital, Fairview, thirty-four to Vergemount Clinic and two to St John of God Hospital. There were seventeen requests under the Freedom of Information Act and eight complaints to the local complaints manager during 2001. All appeared to have been dealt with satisfactorily. There were no research projects undertaken in St Brendan's Hospital governed by the Clinical Trials Act, 1987-1990.

One hundred and seventy eight patients were placed in seclusion in St Brendan's during the year and there were 669 episodes of seclusion. Hospital management should audit the use of seclusion regularly. Where the use of seclusion appeared high, a seclusion reduction plan should be produced which should include monitoring the effect of any change in management regime on the attitude and behaviour of patients. A seclusion register was maintained and the fifteen-minute nursing observations appropriately recorded. A policy and procedure relating to seclusion were under review. The policy and procedure relating to seclusion should be removed from the community residence policy and procedure manual as seclusion was not used at these locations. Fourteen patients were placed on special nursing supervision, one nurse supervising one patient, and there were 414 episodes of special nursing supervision involving duty spans of twelve hours or more. Twenty-two patients were prescribed electro-convulsive therapy at St Brendan's during the year, constituting 142 ECT applications. Arrangements for electro-convulsive therapy were satisfactory. There was a dedicated ECT suite comprising a separate waiting and recovery area. There was a policy for ECT and a named consultant psychiatrist responsible for the ECT clinics.

The system of reporting accidents and incidents involving patients appeared satisfactory. There was a common management analysis of all untoward incidents and accidents and these were categorised according to injury. There were twenty-six accidents to patients, one resulting in serious injury and thirteen resulting in mild injury, such as scratch or

bruising. There were six accidents to staff, two resulting in mild injury. There were seventy-three assaults on patients by other patients, twelve resulting in mild injury and no serious injury and there were seventy-one recorded assaults on staff, nineteen resulting in mild injury and one deemed serious.

Each patient in the admission department of St Brendan’s Hospital should be allocated a nurse directly responsible for the patient’s care at ward level on a day-to-day basis (a primary nurse). The clinical nurse manager should determine the number of patients each primary nurse should have direct responsibility for and the assigned primary nurse should have responsibility for nursing care plan documentation and for the presentation of clinical aspects of the patient’s condition at all multi-disciplinary review meetings. All staff members in contact with patients and members of the public should wear identifying name badges, which indicate their role within the professional team.

RECOMMENDATIONS

It is recommended that:—

1. The plan proposed and presented by the St Brendan’s Management Team relating to the provision of new and upgraded facilities which will result in the closure of St Brendan’s for admission purposes and for the putting in place of specialist services for the homeless and for intensive care purposes and developments on campus be proceeded with as a matter of urgency.
2. Community residences be extensively refurbished and maintained at an acceptable standard.

ST VINCENT’S HOSPITAL, FAIRVIEW; PSYCHIATRIC UNIT, MATER HOSPITAL; AREA 7 MENTAL HEALTH SERVICES — 2002 INSPECTION

INSPECTED ON 13 NOVEMBER, 2001

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

IN-PATIENT CARE

In-Patient care was provided at St Vincent’s Hospital, Fairview where ninety-two beds were provided and at the fifteen bed Acute Psychiatric Unit, Mater Hospital.

Age and Length of Stay of all Patients at 31.12.01

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	19	18	8	2	47	54.0
3-12 Months	—	—	3	5	3	3	14	16.1
1-5 Years	—	—	5	8	2	4	19	21.8
> 5 Years	—	—	—	5	1	1	7	8.1
All Lengths of Stay	—	—	27	36	14	10	87	100.0
% of Total	—	—	31.0	41.4	16.1	11.5	100	

In-Patient Population Diagnosis (31.12.01)

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

(Details of Diagnosis not available).

Status of In-Patients on the date of inspection 2002

Status	Male	Female	Total
Voluntary	32	35	67
Temporary	16	8	24
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	48	43	91

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
959	6.9	153	16.0	82.9	17.1	855	0

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	50	1,334
Day Centres	4	158	360
Out-patient clinics	16	718*	4,364

*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
5	39	2	28	2	32

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
21	32.85	223	58.73	13.8

COST

The cost of the Area 7 Mental Health Service was €15.67 million in 2001.

GENERAL COMMENTS

The Area 6 mental health service serviced St Vincent’s Hospital, Fairview, where there were four sectors with a further sector being serviced by the Mater Hospital Psychiatric Unit. It also provided an acute assessment service for later life psychiatry, an adolescent service apparently of out-patient nature only, a day hospital service based in the grounds of St Vincent’s Hospital for the entire catchment area, and a family therapy service based in St Joseph’s Adolescent Unit in the grounds of St Vincent’s. A specialised rehabilitation service, consultant-led, was to be put in place very shortly. An in-patient and adolescent unit was to be constructed before long in the grounds of St Vincent’s with a wider remit than the catchment area of Area 7.

There was a serious shortage of community-based facilities in this service and very limited day and community residential services. Those that did exist were far from ideal so that, for example, there was an aspiration to move the Ballymun day centre from its existing location to a new Ballymun location in the Axis Centre. The day centre at St Laurence’s Road, Clontarf, as mentioned in previous reports, was in very poor condition and needed a great deal of maintenance input and upgrading. The leaking roofs, which were reported last year continued to be a problem. There were significant structural problems with 108 North Strand Road, which had not changed since last year’s inspection. The premises at 62-63 Eccles Street was in poor decorative repair, although some re-decoration and refurbishment had taken place since the last inspection. The sector out-patient service currently based in Conolly Norman House, on the North Circular Rd, should move to this unit and consideration should be given to providing a day hospital on the premises. It was expected that the sector headquarters would be based at 63 Eccles St from spring 2003.

The premises on Eccles Street, which belonged to the Mater service, apart from one floor, which was occupied by a children’s crèche for the Mater Hospital generally, had been refurbished on the three floors above but no facilities for patients had become available. This was particularly disappointing, as, in last year’s report, it had been suggested that a day hospital should be placed in this building, given that there was no day facility in the sector for the Mater service. Additionally, there were no community facilities of any

description in the sector i.e. any further day services or community-based residential facilities. A decision, probably to become a directive before too long, from the Mater executive that two beds be set aside for children and adolescents had greatly disturbed the staff of the unit. Their concern about this proposed arrangement was shared by the Inspectorate who was committed to opposing the placing of any person under sixteen in an adult psychiatric unit. Apart from the general and clinical undesirability of such a practice, serious issues in relation to the protection of children's rights and Garda clearance of staff employed in looking after young people raised major questions of disquiet. That two such beds should be taken from a complement of fifteen, of which up to half could be used for liaison non-sector patients, was an unacceptable development. The unit was, as was pointed out before, too small, too cramped to function as a psychiatric unit in any real sense of the word. There was no adequate observation capacity for acute patients and no adequate space for the purposes of activity or relaxation. The garden space adjoining the unit was available in a complicated way by patients having to leave the unit to gain access to it. It would be far preferable if direct access were available from the unit.

The centralised and autonomous day hospital operation in Crannog at St Vincent's served all sectors and was run by a separate team with no direct relationship with sector teams who referred patients. In addition, the Inspectorate was not convinced that its seven days a week, twelve-hour day operation was cost-effective, given the relatively low level of activity that was observed on inspection visits since it opened. There was also the impression that, although there appeared to be a theoretical commitment to dealing with acutely ill persons, the day-to-day operation was towards less acutely ill or disturbed persons. There was an out-reach or home care component to its activity but this was not evaluated in any depth. The Inspectorate would regard the establishment of multi-disciplinary sector-based teams with a greater community orientation and day and community residence facilities as a priority in this service. The Inspectorate would exemplify what needs to be done by pointing out that there was only one social worker, based in the North Strand Sector, and in the Mater Sector only one psychologist shared between the service, liaison and academic components.

St Vincent's Hospital, Fairview served a number of purposes. There was the acute admission unit with its locked self-contained acute assessment area. Apparently, all temporary patients and patients unknown to the service i.e. those, the majority of them voluntary, who had never been in the service before, were directed to this locked area in the first instance. The Inspectorate was not entirely happy with this arrangement and felt that it was not appropriate that newly admitted patients, even if they did not object to it themselves, were taken to a locked unit at first introduction to psychiatric in-patient care. This was all the more so as the physical accommodation in this locked unit left something to be desired and, for example, did not have a non-smoking area. Staff, however, revealed that this locked area had reduced tension in the admission ward of St Louise. Since they had no access to an alternative, such as in a free-standing intensive care unit, and not being helped in this regard by St Brendan's, there was little alternative to dealing with acute aggression or disturbance other than in this facility. The safe room provided needed improved observational qualities and the mattress on the floor should be replaced by more suitable sleeping accommodation.

The case note structure in the unit was generally satisfactory but not always used as it should be and the top sheet did not provide basic information such as date of admission, legal status and ICD numerical diagnoses. The completion of admission evaluation and programme planning documentation was variable, in some instances being satisfactory, in others not. A lack of written policy and documentation was noted in relation to the use of the acute assessment area, which was an omission that needed urgent attention. There appeared to be a lack of purposeful occupational and recreational activity in the unit overall. The unit for later life psychiatry containing four patients on the day of inspection appeared to function satisfactorily and was an integral part of the later life psychiatry service for Areas 6 and 7.

The older St Vincent's building provided accommodation that was generally comfortable but old-fashioned. It consisted of four wards, one ten-bedded with a private patient function and which was also used for overflow patients from St Louise admission. Since St Mary's ward contained few patients, its cost efficiency as a unit was not apparent to the Inspectorate. Two other wards catered for elderly patients, some with severe physical disabilities and many more suited to nursing home care than modern in-patient psychiatry. Finally, there was a long-stay ward called a rehabilitation ward in which no very obvious rehabilitation purpose or function was detected and which included accommodation for five long-stay patients from the Mater sector being looked after by a Mater consultant. Many of the patients here were elderly and had to climb to a higher floor for their sleeping accommodation. No doubt, the purpose of this ward would be rationalised with the arrival of the rehabilitation consultant but obviously much more needed to be done from the point of view of active rehabilitation.

Overall, St Vincent's Hospital was something of an anachronism both in the number of functions that it purveyed and also because, contrary to policy, it was free-standing and not part of a general hospital complex.

The Mater psychiatric unit was unsatisfactory in its physical layout and ill adapted to modern psychiatric functions. It functioned partly to cope with in-patients from the sector area and also for liaison purposes. A day hospital, day centre and community residential accommodation were required for this sector. There was also a need to recruit psychology, social worker and occupational therapy staff. Out-patient services should re-locate from Conolly Norman House, North Circular Road to Eccles St pending the provision of out-patient facilities in the new out-patient building at the Mater Hospital.

There were twenty-four temporary admissions to the Mater Hospital and 140 patients admitted on temporary certificates to St Vincent's Hospital last year. Five of the patients admitted as involuntary patients to the Mater Unit were re-graded to voluntary status during the course of their hospitalisation. Information relating to the number of patients admitted as voluntary patients and re-graded to involuntary status and the number of involuntary admissions re-graded to voluntary status at St Louise's Unit, St Vincent's Hospital, Fairview was not available. The service providers should ensure statistical data

relating to re-grading of temporary and voluntary patients during the course of hospitalisation was kept. Nine patients had their involuntary admission orders extended at St Vincent's Hospital during the year. There were 411 liaison consultations by consultant psychiatrists to the general wards of the Mater Hospital and a further 223 consultations to the A & E Department. Thirty-four patients were admitted to the Psychiatric Unit following liaison consultation and a further 166 were referred to the local out-patient psychiatric department. Of the 855 discharges from this service last year, twenty-seven patients took their own discharge against medical advice. Appropriate procedures were in place to follow-up these patients if deemed clinically necessary. There were no deaths in the service last year. Information relating to in-patient population by diagnosis for the 31st December was not available for the acute unit, Mater Hospital or St Vincent's Hospital, Fairview. Procedures should be put in place to ensure this information was recorded.

The Department of Later Life Psychiatry provided services for the Area 6 and Area 7 catchment areas and there were 145 patients on the register at the end of the year. Of the 697 referrals last year, 470 were first referrals and the remainder return referrals. Six acute assessment beds were provided at St Vincent's Hospital, Fairview and there were forty-five admissions to this unit last year.

There were twenty-four complaints made by patients or relatives to the local complaints appeals manager and two requests under the Freedom of Information Act. All appeared to have been dealt with satisfactorily. There was no identified complaints manager for St Vincent's Hospital, Fairview. This matter should be rectified and the name of the complaints manager should be brought to the attention of all service users. All patients, irrespective of their status, must 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, with the clinical nurse manager. Voluntary patients should have a choice of remaining in the open or the locked assessment area of St Louise's Unit, St Vincent's Hospital. Voluntary patients entering the locked assessment unit should have their rights fully explained to them and this should be recorded in the patients' case notes. The principle of the least restrictive alternative forms of hospital care must apply at all times in relation to voluntary patients. The rights of detained patients should be prominently displayed. Upon admission, or as soon as practicable thereafter, the patient must be informed of his or her rights. This information should be given in writing by handing the appropriate patients' rights leaflet to the patient with a verbal explanation of the contents. An entry should be made in either the patient's nursing or medical documentation that an oral and written explanation of patients' statutory legal rights had been given with an indication of the patient's comprehension. If the patient was clearly incapable of understanding, this should be recorded and the information should be repeated at regular intervals using professional judgement to decide the patient's capacity for understanding.

The Inspectorate was pleased to report, following suggestions of last year, that a system had been put in place to track and trend all episodes of seclusion, special nursing and prescription of electro-convulsive therapy for both St Vincent's and the Mater Hospital unit. There were seventy-two episodes of seclusion at St Vincent's and seven at the St Aloysius Unit, Mater Hospital last year and twenty-five patients at St Vincent's and four

at the Mater were placed in seclusion during the year. A regular audit of the use of seclusion should be kept, particularly at St Vincent's Hospital. Whilst facilities at St Vincent's were structurally appropriate, there were a number of small blind spots. Appropriate room furnishings should be provided for the safe room at St Vincent's Hospital. A seclusion register was maintained but the signature in full of the doctor authorising each seclusion episode should be recorded. On examination of the seclusion register, it was noted that the seclusion and restraint portion was completed for each individual seclusion episode. On further enquiry, it was noted that restraint was not used at St Vincent's Hospital and this section of the register should not be completed. There was an updated policy and procedure with guidance for staff on the use of seclusion. Whilst the hospital policy ensured the safety and well-being of the patient and ensured patients received the care and support rendered necessary by his or her seclusion both during and after it had taken place, there was a need to distinguish between seclusion and time out. Two patients at St Vincent's and four at the St Aloysius Unit, Mater Hospital were placed on one-nurse to one-patient special nursing supervision and there were eight episodes at St Vincent's and thirty-seven episodes involving duty spans of ten hours or more last year. Six patients were on prescribed recorded observations (level II observations) at the Mater Hospital last year, whilst there was a policy for level II and level III observations at St Vincent's Hospital. It appeared that no patients were placed on this level of observation last year. On checking nursing documentation, it was noted that one patient was assessed as being suicidal. Where a condition had been recorded, for example, suicidal, no further therapeutic intervention had been recorded. Therefore, it was not possible to determine if such issues had been considered. Following a nursing assessment, if patients were deemed suicidal, the matter should be reported immediately to the medical staff with an appropriate entry in the nursing notes and, following a decision by the medical staff or a joint decision between medical and nursing staff, patients deemed at risk should be placed on either level I or level II special nursing supervision. Fourteen patients at the Mater Hospital were prescribed electro-convulsive therapy last year. Two of these patients came from St Vincent's Hospital, Fairview, one from St Brendan's and five from St Ita's Hospital. Seventeen patients, (thirteen female and four male patients) were prescribed electro-convulsive therapy at St Vincent's Hospital, Fairview during the year.

Whilst the reporting mechanisms relating to accidents, incidents and assaults within St Vincent's Hospital were of high standards, for quality and audit initiatives to have a positive impact, some essential features were necessary. At St Vincent's a group of three senior staff met regularly to review major incident reports. Any major incident was investigated using the agreed guidelines provided by the Department of Health and Children.

Generally, staff appeared aware of the importance of approved policies, procedures and guidelines, all of which had been reviewed and updated within the past two years. Guidelines relating to the degree in nursing programme should not be contained within the clinical procedures and policy guidelines, which should specifically relate to patient care. Policies were formally introduced to relevant staff ensuring awareness and understanding of content. Staff signed a document to state that they had read, understood and intended

to and were able to comply with policy content. This was very satisfactory. A written policy on patients' voting rights should be included in the policy manual.

A number of clinical files were examined, and it was noted that the personal data sheet was not completed in full on a number of files, which did not contain the name of the next-of-kin, name, relationship and telephone number of next-of-kin, name and address of general practitioner. The patient's hospital status, whether voluntary or temporary, was not recorded. This matter required attention. The special form for the recording of the history of patients' present condition, previous psychiatric history, treatment at time of assessment, family history, mental state assessment and immediate management plan had not been completed in a number of files. It should be noted that these assessments were done but recorded within the continuation pages of the clinical notes.

A number of nursing files were examined in St Vincent's Hospital where the 'Roy' model of nursing was in use. There was appropriate training for all staff on the use of the nurse/care planning system. Entries in the nursing care plans identified problems that had arisen and actions taken by staff to rectify them. Records were accurately dated and timed but the signature in full of the nurse making the entry should be recorded with block lettering alongside the signature of the first entry. The patient's name, date of birth and address was appropriately recorded on each continuation page. Some nursing documentation recorded that patients should be kept under close observation and there was no definition as to what this meant. This should relate back to the levels of observation in the hospital policy manual. Ideally, the patient's primary nurse should be entered in the nursing record and the record should reflect the involvement of patients in planning and making choices and decisions about their own care and treatment. Similarly, evaluation of nursing care plans should include the patient's own views about progress in addition to the nurse's views and any negotiated changes in the nursing plans and the results of these changes. By and large, records had an entry relating to how patients settled into the ward at the end of their first day of hospitalisation.

The policy and procedure relating to patients absent without official leave should be reviewed. This document should contain information requiring staff to indicate when the patient went absent without official leave who had responsibility to return the patient, who needed to take charge of the absent without official leave procedure, how a local search was organised, when and whom should contact the Gardaí and when and whom should contact the patient's relatives.

Three patients were interviewed to assess their opinion of the services provided. One was on a first admission and detained on a temporary form and was six weeks an in-patient. The other two were of voluntary status and had numerous previous admissions and their present admission lasted eight weeks and twenty-four weeks respectively. All patients were quite happy with the admitting procedures and were introduced to the primary nurse system and to their consultant psychiatrists. They were pleased with the frequency of medical and nursing consultations and at all times were treated with dignity and respect. Nurses were always available to them with help, therapy and advice. All patients stated

they had not received any explanatory booklet or leaflet pertaining to the hospital and its facilities and neither were they aware of patient care plans and personally felt they were not involved in such. Neither were they aware of the complaints procedures. Such explanatory booklets were visible in various patient areas but the patients' attention did not appear to have been drawn to them. The same applied to literature on medications. Written information on this subject should be brought to the attention of each patient individually and it would be prudent to have them sign a record to the effect that they understood fully the effects of such medications and that they had given their consent to taking them.

All patients were quite happy with the hygiene, décor and general ambience of the unit but they did have reservations about various aspects. Two complained that the heating was not satisfactory, while one complained about the quality of the meals provided. All felt that they became bored in the evenings and at week-ends for want of appropriate activities. In general, they felt they would like to get out of the unit more frequently and would like more attractive leisure time activities. Their overall impression, however, of the services was quite positive.

RECOMMENDATIONS

It is recommended that:—

1. There be a considerable expansion of community facilities such as sector headquarters, day hospitals and community residential accommodation in this service.
2. Existing community facilities be refurbished, up-graded or replaced as appropriate.
3. The use of the 87 St Laurence's Road premises be reviewed with consideration being given to conversion of part of the premises to a day hospital sector headquarters function.
4. Residential accommodation at 87 St Lawrence's Road be urgently considered for up-grading and refurbishment.
5. Adequate multi-disciplinary staff be recruited to provide a skill mix service in the sectors.

DUBLIN NORTH-EAST (AREA 8) MENTAL HEALTH SERVICE

ST ITA’S HOSPITAL PORTRANE — 2002 INSPECTION

INSPECTED ON 11 DECEMBER, 2002

GENERAL DESCRIPTION OF THE SERVICE

The population of the catchment area was 201,617, and it was divided into five sectors as follows:—

Sector	Population
Kilbarrack East	40,062
Kilbarrack West	31,946
Coolock	25,289
Killester	24,621
Dublin North County	79,699

IN-PATIENT CARE

In-Patient care was provided at St Ita’s where 234 beds were provided in male and female units.

Age and Length of Stay of all Patients on 31.12.01

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	23	10	9	5	47	23.4
3-12 Months	—	—	1	4	7	3	15	7.5
1-5 Years	—	2	3	3	11	9	28	13.9
> 5 Years	—	—	4	26	36	45	111	55.2
All Lengths of Stay	—	2	31	43	63	62	201	100
% of Total	—	1.0	15.4	21.4	31.5	30.8	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
28	98	6	23	8	—
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
5	4	2	4	23	201

Status of In-Patients on date of inspection

Status	Male	Female	Total
Voluntary	83	89	172
Temporary	8	7	15
P.U.M.	—	—	—
Ward of Court	9	5	14
Total	91	96	187

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
857	4.24	208	24	91.4	8.6	801	30

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	3	85	277
Day Centres	2	55	80
Out-patient clinics	19	1,829*	2,864

*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
2	26	4	31	1	6

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
32	28	238	48	7.5

COST

The cost of St Ita’s Mental Health Service was €25.14 million in 2001.

GENERAL COMMENTS

All the sectors in the service had consultant-led teams. Unfortunately, the teams were not multi-disciplinary in that, while some of them had social workers, there were only two occupational therapists and a part-time psychologist in the entire service. Similarly, not every sector had a sector headquarters or a day hospital. Sector headquarters were provided in Swords and in a vestigial form in Raheny, Coolock and Balbriggan. There were day hospitals operating in Raheny and Swords. Neither functioned as acute day hospitals. There were day centres in Artane and Coolock. Evidently, there was a considerable need for expanded community development to remedy the deficit referred to.

During the past year, there had been some initiatives and developments. The St Anne’s Terrace of six houses on the St Ita’s campus, which was in poor condition, was now closed. The fourteen patients who had been there were re-distributed to other residential facilities within the service. The most significant move was five former residents being transferred to House 100, a group home on the hospital campus, which was currently functioning as

a high-support community residence. Inch House, a high-support community residence that had recently opened, had a capacity for nine patients. Unit 8, formerly a ward for elderly patients had closed, its former residents being re-distributed, some of them discharged from St Ita's to nursing home locations. The empty unit had been converted to a six-bedded assessment facility for psychiatry of later life and was due to open for this purpose the day following inspection. This was regarded as a temporary measure pending the opening of the acute psychiatric unit in Beaumont Hospital for this catchment area service and which would contain a six-bedded acute assessment unit for the elderly service. Three new houses had been acquired, two in Donabate as low-support community residences and one in Rush as a medium-support residence, and would take patients from various locations, such as the Woodview Lodge community residence in St Ita's complex. This premises was in poor condition and would then be closed.

New services established in this catchment area included a specialised rehabilitation team. Unfortunately, so far, this team had no dedicated rehabilitation premises which it badly needed but was focusing its attention on Woodview House, a large residence on the St Ita's campus. The specialised service for the elderly, as already mentioned, had acquired a temporary acute assessment unit within St Ita's Hospital pending the projected accommodation for this purpose in the psychiatric unit in Beaumont Hospital. A consultant psychiatrist with tenuous links to the other St Ita's teams provided liaison consultation services at Beaumont Hospital to the Accident and Emergency Department and to the general wards. Two home care teams were operating in the St Ita's service, one in Swords another in Balbriggan. Both services existed simultaneously with the conventional community operation, largely based on community nurse activity, in both sectors. The extent that these services operate conjointly or independently was something that was difficult to evaluate.

St Ita's was a large hospital, once housing 2,000 patients, and now divided into two clinically separate services. St Ita's served the Dublin North City and all of Dublin North county for mental health services. The other St Joseph's service for intellectual disability had been the subject of an independent inspectorial report. Between them, the two services catered for approximately 421 patients. Because of the threefold reduction in patient numbers, large areas of St Ita's were empty without identified future roles as far as the Inspectorate could determine. These empty buildings were, on superficial inspection, in good structural order but obviously needed expensive maintenance such as heating. The failure of the board to identify a role for them was puzzling, and a similar comment seemed appropriate in relation to the 300 or so acres of land on which St Ita's stood. The immediate availability of land and buildings concentrated on the St Ita's campus, provided opportunity for possible development of the service. However, there had been a growing realisation that it was increasingly important to place services near the community they served, thus some consideration of the isolation of St Ita's should be taken into account.

There were approximately 185 patients present at St Ita's mental health service on the day of inspection, consisting of two groups, a small number of acute patients catered for by two acute admission wards of approximately forty-eight patients, and the remainder of the patient clientele all elderly long-stay, very few of whom were under sixty-five with the

majority over seventy-five. The St Ita's population had been reducing year after year and this year was approximately thirty down on last year's numbers. Factors contributing to this reduction included discharges to nursing homes and a more structured admissions policy in relation to persons over sixty-five. It could be projected that this long-stay elderly population would have dissipated in another ten years. By that time — and hopefully long before it — the acute component would be catered for in Beaumont Hospital. St Ita's would then, as a mental hospital as distinct from an intellectual disability hospital, have ceased to exist. It could hardly be regretted, given the relatively poor accommodation available to the elderly in St Ita's. Whereas Ward 1 Male and Ward 1 Female were possibly acceptable, Reilly's Hill complex comprising Units L, M, N and P were not. The overcrowding, lack of day space, absence of smoke-free areas, large dormitories and so on, as detailed in the body of the report, all contributed to the unsatisfactory nature of these buildings. However, a plan was envisaged whereby in a short number of years, these four units in Reilly's Hill would be closed and replaced by two purpose-built twenty-five bedded units for the elderly specifically dealing with dementia.

The two acute admission wards, one male, one female, were quite unacceptable for their purposes and highlighted the extreme urgency of providing a much-delayed acute unit in Beaumont Hospital. Even the ECT machines, apparently, were unsatisfactory. An admission policy to the unit was not apparent and admission decisions quite often appeared to be vested in relatively inexperienced doctors. Furthermore, there was an impression that newly admitted patients were often not seen by consultants within twenty-four hours of admission and, indeed, in one case note examined (that of a first admitted patient six days previously), there was no indication of a consultant case note entry. The case note structure, organisation and entries were not of a satisfactory level. In Reilly's Hill, the case notes of two temporary patients were examined in an attempt to derive some information about their legal status, extension of temporary patient reception orders or re-certification. In neither case was there any indication in the case note as to legal status and, indeed, the top sheet did not allow for its recording. The identification of these patients as involuntary rested on oral tradition within the ward. Several case notes gave no indication that the patients had been re-certified or that their period of detention had been extended. This matter was brought to the attention of the staff on the wards and they were requested to check with the general office as to the legal status of these patients and, if it were involuntary, whether it had been re-certified or extended. The Inspectorate was unable to check independently as this matter was discovered after 5.00 p.m. In one of the wards of Reilly's Hill, a patient had been registered in the seclusion/restraint book as being restrained on four occasions during the year. On further enquiry, however, in fact, seclusion rather than restraint had been practiced; the medical case notes were unhelpful in this regard as they contained no entry in relation to these episodes of supposed seclusion. Primary nursing arrangements were not in place in the admission units and patient reviews with all staff participating did not occur in the longer-stay wards. In these wards, efforts to introduce nursing care plans had been made, but what had eventuated, in fact, were nursing notes.

It was not apparent that a planning process, coherent and comprehensive, existed in this service. The Inspectorate believed there were sufficient preoccupations to warrant it and drive it forward, particularly in relation to expediting the acute unit at Beaumont, the

possible de-designation of all the units in Reilly's Hill, the rationalisation of the rehabilitation service premises, particularly as this related to Willowbrook, better communication with the liaison service in Beaumont Hospital, review of staffing arrangements and the Inspectoral perception of over-staffing and lack of skill mix in certain elements of the service. The wider issues of the use of the vacant buildings in St Ita's and the extensive parcel of land on which it all stood as possible potential funding sources for community development urgently needed consideration in the Inspectorate's view.

Seventy-four patients, thirty-four male and forty female, were admitted on temporary detention orders in 2001 and twelve had their temporary detention orders extended during the year. Thirteen patients admitted as involuntary patients were re-graded to voluntary status during their hospital stay and fifteen patients admitted as voluntary patients were re-graded involuntary during the course of their hospitalisation. Fourteen patients from the community lodged overnight in St Ita's Hospital but were not formally admitted. This was a big reduction from forty-eight the previous year. Sixty-six patients discharged themselves from the hospital against medical advice and appropriate arrangements were in place to follow up these patients. There were five requests made to the local complaints manager under the Freedom of Information Act and all appeared to have been dealt with satisfactorily. Statistical information relating to the number of complaints was not available at the time of inspection. Sixteen accidents to patients and six accidents to staff were recorded in 2001. Ten of these accidents required medical intervention. There were five recorded assaults on patients. All of these were verbal altercations, resulting in no injury. There were three recorded physical assaults on staff by patients with no detectable injury.

Sixty-two patients were placed in seclusion and there were 108 episodes of seclusion in the service during the year. Facilities for seclusion in the admission unit were structurally appropriate. The seclusion facility at Willowbrook was out of commission at the time of inspection. The practice of transferring patients from the admission units to this facility should be phased out. There was adequate privacy for patients in the safe rooms at both admission units and observation was appropriate. Seclusion registers were maintained and kept up to date. Seclusion authorisations should contain the signature in full of the authorising doctor. Nursing observations should record when seclusion commenced and terminated.

As mentioned in previous reports, the standard of medical and nursing records within the Area 8 mental health service varied. Guidance notes on the order of assembly of the medical file were printed on the back cover. Each newly admitted patient had a full medical evaluation, including comprehensive admission notes, mental state examination, physical examination and immediate management plan clearly documented in all notes examined. The assessment form required the signature in full of the doctor inputting the information in the clinical notes. There was provision for the recording of the patient's name on each continuation page of the medical file but this was not always recorded. The date of record entries was stated but the time of assessment was not. There was considerable clinical material stored in the pockets of files. Risks associated with this included lost or misfiled clinical information and delayed access to pertinent information. The nursing notes examined in the admission units used the 'Orem' human needs model of nursing.

Biographical data on each patient was well documented in the nursing notes. Patients' physical observation, temperature, pulse, respiration, blood pressure, urine analysis, etc. were all well documented as part of the initial nursing assessment post-admission. Appropriate safety considerations were also documented which was very satisfactory. All entries were accurately dated. Time of entry should also be recorded using the 24-hour clock. A primary nursing system should be introduced in the admission units and the name of patient's primary nurse appropriately recorded in the nursing documentation. Abbreviations were not noted in the notes examined but the service had a policy on approved abbreviations. The nursing records were audited to assess standard of record and identify areas for improvement and the service had been working on the introduction of a new nursing care plan since the previous inspection. A discharge-planning group had been established to examine the situation of bed utilisation and bed occupancy and identify problems or deficit areas in the admission and discharge planning arrangements. Documentation pertaining to a quality improvement survey relating to admission and discharge after-care had been introduced since the last visit of inspection.

Revised and updated generic safety statements for the Northern Area Health Board had been introduced since April, 2002. The older generic statements dated 1992 should be removed from the safety file in clinical areas. One copy should be stored in a central location for future reference. Local safety statements were now required for all local units adhering to the standards and procedures set by the Safety and Welfare at Work Act, 1989. These local safety statements should supplement the generic statement and a copy should be in each local area and hazard control sheets should be available indicating periodic safety audits of all areas. A hospital advisory committee, took responsibility for fire and safety considerations and records were kept of all meetings. There was periodic fire awareness training for all staff and records were kept in a fire log. In certain areas, staff carried personal safety alarms which would enable a speedy response in emergencies. A written policy and procedure relating to the use of these alarms was required. All staff were generally aware of their responsibility in relation to personal safety and the safety of patients and colleagues. A robust system should be in place to ensure staff did not remove personal safety alarms from the premises at the end of their tour of duty. This was causing some difficulty within the service and was an important issue that needed to be addressed as a matter of urgency. The management team of this service met informally on a monthly basis and it was recommended that minutes of all meetings be kept. The management team should conduct an annual review of the quality, efficiency and effectiveness of the service as a whole and of each of its constituent parts. This review should identify strengths and weaknesses in policies and programmes with a view to improvement and revision. An annual report should be produced setting out the achievements during the year and the targets for the coming years.

The importance and values of policies and similar documentation had been recognised within this service. A multi-disciplinary committee had reviewed all policies, procedures and protocols and many of the updated policies, procedures and protocols had been introduced. The content of these was generally found to be detailed and unambiguous, often with responsibilities clearly defined. Policies were formally introduced to relevant staff ensuring awareness and understanding of content and it was noted that staff signed a

document to say that they had read, understood and intended to and were able to comply with policy content. There was a need for regular review of policy and procedure validity and this should be incorporated into an audit process to enable assessment of efficacy and compliance.

Information relating to complaints and patients' rights under the Mental Treatment Act, 1945 and amending legislation should be included in a hospital brochure and displayed prominently on the patients' notice boards in the admission units and all other areas where patients were hospitalised under the Act. All patients, irrespective of their status, must 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. Informing patients of their rights consisted of two tasks; the first was providing written information via the notice board or information leaflet and the second was satisfaction relating to patients' understanding of explanations given. Upon admission or as soon as practicable thereafter, the patients should be informed of their rights. Ideally, this information should be given in writing with a verbal explanation of content. Entries should be made in the patient's nursing process documentation that an oral and written explanation had been given with an indication of the patient's comprehension. If the patient was clearly incapable of understanding the explanation given, this should be recorded and the information should be repeated at regular intervals using professional judgement in deciding on the patient's capacity for understanding.

The guidance notes on the management of illicit drug use or drug-related incidents dated 2nd June, 2000 setting out the action to be taken if suspicion of illicit drug use or supply or policy for staff to search and confiscate illicit drugs or alcohol or dangerous weapons and arrangements regarding disposal of illicit drugs or dangerous articles should be reviewed and included in the revised and updated policy manual. A procedure should be in place relating to seeking feedback from patients and their families on service provision. The patients' money management system at St Ita's Hospital appeared satisfactory but a system should be in place for informing patients of hospital charges. The service had a smoking policy, but smoking arrangements in admission units was far from satisfactory. The issuing of cigarettes and tobacco products to patients from the hospital stores should be discontinued.

A written policy for the ordering, prescribing, storing and administration of medicines was required for all clinical areas. The standard of prescription writing in this service was generally satisfactory. There was a low risk factor of drug error as most of the prescriptions were in block writing and those that were scripted were not difficult to read. Written instructions for the use of prescription cards was required. Whilst each prescription was signed and dated individually, the prescriber should use their signature in full to enable easy identification of the practitioner in the future. The drug administration card should have provision for the nurse's signature in full. Whilst there was provision for recording of drug allergies or drug sensitivities, so that information was rapidly available to staff, this was not always completed and no reason was given. If there were no known drug allergies or sensitivities, this should be recorded. There was an increased risk factor of drug error on a number of cards, where the number of discontinued prescriptions exceeded the

number of current prescriptions. All of these cards required re-writing. The date and signature of drugs discontinued was not always completed. The system of drawing a line through the prescription and not completing the discontinuation column was not satisfactory.

A number of patients were interviewed to assess their opinion on the level of service provided to them at the hospital. Patients were quite positive in their response and were generally pleased with the services. All were satisfied that, on admission or within a reasonable time thereafter, they were appropriately introduced to the professional team responsible for their care and were happy with the admission process and courtesy and helpfulness of staff. Each patient knew the name of their consultant psychiatrist and had frequent consultations with them. Patients were not offered an information booklet about the hospital, and were not aware if there was a primary nurse allocated with responsibility for their care whilst hospitalised. Patients were not aware of the existence of a nursing care plan. Patients reported that they were not made aware or given access to information about their rights under the Mental Treatment Act, 1945 and amending legislation or of the local hospital complaints procedures. All patients complained about the inadequate smoking areas and day facilities at the admission units. Otherwise, they were satisfied with the cleanliness, heating and other facilities provided by the unit. Patients were generally satisfied with the interesting and beneficial activities provided in the activity centre. Patients reported that they had been given reasonable information about the nature of their medical condition, including prescribed medication. One patient, stated he did not understand the explanations given relating to prescribed medication, but did not inform the doctor of this as he felt the doctor did not have the time to deal with it. The patient stated that he would like written information on prescribed medication and if he did not understand this, he would be in a better position to ask the doctor for an explanation. Patients were generally satisfied with all aspects of privacy and dignity in relation to their care and all reported that there was adequate respect for their privacy when being given information about treatment.

RECOMMENDATIONS

It is recommended that:—

1. The establishment of a comprehensive authoritative planning group to deal with many issues but, as a primary consideration, the future of St Ita’s Hospital, including the current vacant buildings and the 300 acres on which it stands.
2. The expansion of community services to ensure sector headquarters and day hospitals for all sectors. The recruitment of additional psychology and occupational therapy personnel to make each sector truly multi-disciplinary.
3. A review of the elderly patients in Reilly’s Hill, with consideration of the possibility of reducing their numbers through transfer to nursing home locations.
4. A detailed clinical audit review of the process of clinical decision-making in relation to the patients admitted as in-patients or deviated to more appropriate community-based interventions and the level at which such decisions are made, to review the time lapse between admission and consultant evaluation, to review the setting up of clear

- programmed approaches to patient care on admission with patient participation and any other relevant issues concerning clinical management.
5. A review of case note structure including, particularly in the case of longer-stay patients, a top sheet that sets out unambiguously and clearly basic data, such as legal status.
 6. The introduction of a primary nursing regime in the admission wards and an approved system of patient clinical review in longer-stay units.

ST JOSEPH’S INTELLECTUAL DISABILITY SERVICE — 2002 INSPECTION

INSPECTED ON 6 NOVEMBER, 2002

IN-PATIENT CARE

In-Patient care was provided at St Josephs Intellectual Disability Service, Portrane where 251 beds were provided in seventeen nursing units.

Age and Length of Stay of all Patients at 31.12.01

Age Length of Stay	Under 16	16-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	2	3	—	—	—	5	2.0
3-12 Months	—	2	3	1	—	—	6	2.4
1-5 Years	—	—	10	3	—	—	13	5.2
> 5 Years	—	—	75	97	43	12	227	90.4
All Lengths of Stay	—	4	91	101	43	12	251	100
% of Total	—	1.59	36.26	40.24	17.13	4.78	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	—	—	—	—	—
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
—	—	—	251	—	251

Status of in-patients on the date of inspection 2002

Status	Male	Female	Total
Voluntary	142	86	228
Temporary	2	—	2
P.U.M.	—	—	—
Ward of Court	5	12	17
Total	149	98	247

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
37	N.A.	9	24.3	97.3	2.71	51	10

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	—	—	—
Day Centres	1	11	11
Out-patient clinics	2	129*	168

*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
4	27	1	3	3	22

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
3	14	284.5	214.5	—

COST

The cost of the St Joseph’s Intellectual Disability Service was €23 million in 2001.

GENERAL COMMENTS

Within St Joseph’s service, there was an apparent need to set up an efficient and effective management structure. While Management Team Meetings had taken place as required, there was a lack of organised groups to deal with, for example, inter alia, health and safety matters.

On ward level, it appeared that certain meetings did take place, varying in frequency, depending on the ward concerned. In general terms, documentation on wards was satisfactory. Thus, medical case note entries did occur, even if these were mainly in response to physical examinations and reports, rather than regular clinical reviews. Prescribing data and sheets relating to patients gave evidence of recent reviews. In general terms, these were signed in full but there were some instances where initials were used and it was pointed out that medical staff should be requested to sign legibly each prescription entry. Seclusion and restraint documentation was kept in order and most of the orders were signed by junior doctors. Patients' money documentation was also well maintained, as were receipts for articles purchased for each individual patient.

The intellectual disability services for the Eastern Regional Health Authority (ERHA) area were provided by a mixture of voluntary and statutory services with the contribution from the voluntary sector coming from a number of different organisations. As mentioned in last year's report, it was difficult to view St Joseph's intellectual disability services in isolation from the inputs of the voluntary organisations. Historically, St Joseph's service had to deal with the more disturbed and difficult patients from the entire region, patients for whom other services were unable or unwilling to provide appropriate care. There was an urgent need to ensure that the intellectually disabled persons in the Eastern Regional Health Authority area were served by a unified, comprehensive and rationally-based service with all elements working together in harmony. The St Joseph's service should be an integral part of the overall strategy for the delivery of services to this disadvantaged group and should not be seen as a port of call operating in isolation from the inputs of the voluntary and other statutory organisations.

St Joseph's intellectual disability services provided 236 beds in seventeen nursing units; thirteen units accommodating 213 patients were locked units. Sixteen activation/occupational therapy units on the hospital campus were attended by 190 in-patients and twenty out-patients.

The burden of administering the intellectual disability service and the mental health service on the campus of St Ita's Hospital and all of its community facilities was falling upon an under-resourced administration. An independent structure should be put in place for the intellectual disability service to ensure that this service could embark on a planning and management programme which it currently lacked. The necessity of providing a one-year and five-year development plan for this service was apparent. Such plans were not in place at present and should be the first task of the independently structured service. As a first step, there was a need for the management team locally to meet formally on a monthly basis and minutes of all formal minutes kept.

The Inspectorate very much welcomed the opening of the Clonmethan facility in Oldtown, Co. Meath. This facility consisted of six bungalows and a day service. The overall physical standards were of a very high order and the patients had settled in well to their new environment. This centre was now operating at full capacity and had facilitated the closure of Unit A on the hospital campus. Prior to this visit of inspection, planning permission had been approved for the construction of a further six houses and day service on the

campus of St Ita's and it was expected that work on this project would commence early in 2003. The St Vincent's community residence on campus would be demolished as part of this development. There was a need to find an alternative location for these residents in the meantime.

In spite of these necessary and welcome developments, a large proportion of St Joseph's intellectual disability service was contained in an institutional setting on the campus of St Ita's Hospital. The Inspectorate felt that, with the separate administrative structure in place as referred to earlier, much if not all of the institutional residential facilities on the hospital campus could be de-designated as the majority of units functioned as residential units rather than hospital accommodation. A small number of units may require designation under the Mental Treatment Act, 1945 but the majority in the Inspectorate's opinion should be de-designated.

There had been considerable improvements to the grounds of St Ita's Hospital over the past two years and a great deal of progress had been made to improve the physical conditions in areas of the hospital occupied by the St Joseph's intellectual disability service. The result of this was evident in the course of inspection. The seating and artwork on the long corridors were particularly welcome which makes them more homely and less institutional and intimidating in appearance. Whilst the upgrading of the kitchens at Rushbrook House was welcomed, the remainder of the house required upgrading. Rushbrook House required extensive internal re-decoration and the exposed heating pipes adjacent to the house constituted a serious safety hazard and should be made safe. Externally, the St Joseph's community residence and surrounding grounds looked attractive but there was a need for extensive internal refurbishment and re-decoration, particularly in a number of houses where there was external water penetration. The Inspectorate welcomed the improvement in the roadways and footpaths adjoining some of the wards following on from a complaint from the patients' residents committee during a previous inspection. Motorised wheelchairs should be considered for a small number of residents who, with suitable training, could use these chairs to ensure greater access to facilities on the hospital campus.

The Inspectorate wished to acknowledge the active involvement and participation of the voluntary association known as the Parents and Friends of St Joseph's. Parents visited formally on a periodic basis and were taken to areas where patients were accommodated and a copy of their report was forwarded to the Inspectorate. The Association over the years had made generous contributions from their funds towards social programmes for patients and in the provision of a holiday home, which was used by many patients over the summer months. There appeared to be a good working relationship between Parents and Friends and the local management and staff.

The difficulties relating to the recruitment of staff and, in particular, nursing staff to this service continued. There were forty-nine whole-time equivalent nursing posts vacant and difficulty was experienced recruiting suitably qualified nursing staff in spite of employing eleven of the twelve recently qualified nurses from the training school. An active recruitment drive was underway to recruit nurses. To meet some of the deficits, nurses' aide

health care assistants were introduced as members of the health care team to assist and support the nursing function. These staff had integrated well into the service and, in turn, were making their own unique contribution to service delivery. There were no occupational therapists, physiotherapists or psychiatric social workers employed in the St Joseph's service. Approval was given for the filling of these posts and the Inspectorate was informed of difficulty in recruiting suitably qualified personnel. The service should continue to attempt to recruit these essential professionals to strengthen the multi-disciplinary team and some form of physiotherapy service should be introduced, particularly in areas of greatest need.

There was an active education and re-training programme for staff and an induction package was provided for all newly appointed nursing and care staff with appropriate records of all training and induction programmes kept. There were 511 episodes of seclusion involving thirty-seven patients in the St Joseph's Intellectual Disability service during 2001. This was a marked increase from 296 episodes in 1999 and 137 episodes in the previous year, 2000. The Inspectorate remained concerned about the physical state of some of the seclusion rooms used. Whilst steam cleaning had been introduced since the previous inspection, it was felt the overall condition of some rooms was less than satisfactory and needed to be upgraded and improved. Seclusion registers were maintained and nursing observations of all episodes of seclusion appropriately recorded.

All staff in this service appeared aware of their responsibility in relation to personal safety and the safety of patients and colleagues and their responsibility in reporting of identified hazards. A personal safety alarm was provided for staff at a number of locations. However, on this inspection, it was noted that many staff were not wearing or carrying the personal alarms. The written policy on the use of the personal panic alarms should be reviewed and updated and all staff should carry the alarms in areas where they are provided. The 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 was dated 1994 and required review and updating by the Safety Committee. Completed hazard control forms should be available at each local area indicating periodic safety audits identifying and classifying risks and setting out the action required to minimise or eliminate all risks. A senior manager should co-ordinate, monitor and implement the safety policy. Management and appropriate staff should be suitably advised and trained in the skills of risk management. This training should include the ability to identify hazards, assess risks and consider appropriate control options.

The medicinal preparations and procedure policy was undated. It was noted that all policies and procedures were under review. New policies should have an individual cover sheet detailing reference numbers, authors of the policy document, monitoring procedures as well as detailing the reference documentation used as evidence base for the policy. Each policy and procedure should be approved by the hospital management and the effective date of its introduction should be recorded.

A new nurse care planning system had been introduced to the St Joseph's service since the previous inspection and each patient had an individual programme plan. This new

system was very much in its infancy and it was too early to evaluate its effectiveness. However, it was noted that a dual system of nursing notes and nurse care planning remained in operation in a number of units. The date of the meeting to decide a patient's individual programme plan was not always recorded, in areas where the new system was in operation. In some areas, only basic nursing notes were recorded.

There were no complaints made to the local complaints appeals manager during the year. The three requests made under the Freedom of Information Act were dealt with satisfactorily. There were no research projects undertaken in this service governed by the Clinical Trials Act, 1987 to 1990. There were 154 accidents to patients, sixteen were deemed serious and 118 resulted in minor injuries. There were sixteen accidents to staff, five resulting in minor injuries. There were forty-four assaults on patients by other patients, eleven were deemed serious and twenty-nine resulted in minor injuries. There were fifty-three assaults on staff, thirty-nine of those resulted in minor injuries. The mechanism for reporting and responding to accidents, injuries and incidents at this service appeared satisfactory.

It was noted on this inspection that cigarettes and tobacco products were issued to patients from the hospital stores. Whilst this was traditional in the old mental hospitals, the Inspectorate has 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. The hospital shop ceased to stock tobacco products a number of years ago as part of a health campaign. Whilst this policy is supported by the Inspectorate, some special arrangement should be made for the more dependent patients who smoke. This, in our opinion, would be far better than issuing large quantities of cigarettes and other tobacco products from the hospital and ward stores. A written smoking policy should be introduced in all ward areas and smoking should be confined to designated smoking areas with all other areas in the hospital non-smoking. Programmes should be put in place to help patients give up smoking altogether or at least reduce their dependence on tobacco products.

RECOMMENDATIONS

It is recommended that:—

1. The St Joseph's intellectual disability service should be autonomous and administratively separate from the mental health service in St Ita's.
2. The programme of relocating patients from the main hospital block to improved and alternative care facilities continue.
3. The service be integrated into the Intellectual Disability Services of the ERHA.
4. A third consultant-led team be established and appropriate multidisciplinary teams developed.
5. Rushbrook House and St Joseph's community residence be upgraded and redecorated.
6. Revived efforts be put in place to establish links with the voluntary agencies providing services in the same catchment area.

7. Seclusion rooms be upgraded.
8. A risk management strategy be put in place and all health and safety statements reviewed and updated.
9. Physiotherapy services be introduced in areas of greatest need.
10. A nurse care planning system be introduced in all units.

CHAPTER THREE

Midland Health Board

LAOIS/OFFALY MENTAL HEALTH SERVICE — 2002 INSPECTION

INSPECTED ON 23 APRIL, 2002

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 111,878 was divided into three sectors as follows:

Sector	Population
Portlaoise	38,334
Tullamore	39,789
Birr	33,755

IN-PATIENT CARE

In-Patient care was provided at St Fintan’s Hospital, Portlaoise, which had 108 beds in one female, one integrated, and two male wards.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	—	20	4	6	2	32	35.6
3 to 12 Months	—	—	3	5	—	—	8	8.9
1 to 5 Years	—	—	2	8	2	3	15	16.7
Over 5 Years	—	—	6	15	5	9	35	38.9
All Lengths of Stay	—	—	31	32	13	14	90	100
% of Total	—	—	34.4	35.6	14.4	15.6	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
6	44	—	14	8	1
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
3	10	—	4	—	90

Status of In-Patients on the date of inspection 2002

Status	Male	Female	Total
Voluntary	55	29	84
Temporary	1	—	1
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	56	29	85

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
768	6.9	168	21.9	92.3	7.7	775	5

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of Persons Attending
Day Hospitals	3	Not Provided	17 per day
Day Centres	4	88	60 per day
Out-patient clinics	11	381*	792

*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
12	59	3	20	2	32

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
10	18	127.5	100.22	13

COST

The cost of the Laois/Offaly Mental Health Service was €12.4 million in 2001.

GENERAL COMMENTS

The most pressing issue in this service, and the cause of great frustration among the service providers, was the enforced delay in moving to the new fifty-bed psychiatric unit at Portlaoise General Hospital. The Inspectorate visited the new unit, which was near completion. Apart from the over-generous provision of beds for the catchment area, the Inspectorate was happy with the design, layout and disposition of beds between close observation, general provision and the six-bed component for older patients. The provision of an internal courtyard space was welcomed and the general quality of the finish

throughout was impressive. However, it was intended that the unit would first accommodate, not psychiatric patients for whom it was provided, but forty-four medical patients coming from the medical wards in the general hospital while these were undergoing renovation. Furthermore, the Inspectorate learnt that the cardiac rehabilitation unit of the general hospital was to be accommodated in the unit, also on a temporary basis. Given that this unit would not be ready to receive these disparate elements for another six months, and that the vacation, renovation, and return of patients to the general hospital wards then had to be achieved, it was evident that it would be, at the very minimum, eighteen months before the psychiatric unit would be given over for its rightful purpose. Pessimists might say that other general hospital requirements would then be likely to arise and require to be accommodated within the psychiatric unit. All of this was the more disappointing because, even despite new arrangements since the last inspection, the two admission wards in St Fintan's Hospital were quite unsatisfactory, for the reasons pointed out in the body of this report.

It was noted that a large number of patients in St Fintan's were ready to move out of the hospital to alternative accommodation. The rehabilitation ward had upwards of twenty patients, all ready to move to community-based accommodation were this available. Unfortunately, it was not, and no patient from the rehabilitation unit had moved to community-based accommodation during 2001. A further seven long-stay patients were accommodated in the male admission unit without any immediate prospect of discharge because appropriate accommodation was not available for them. These shortcomings, together with the frustration of not being able to move to the new psychiatric unit in Portlaoise General Hospital, had a discouraging effect on staff. It is worth noting that this service, unlike those in the ERHA region, had no difficulties in recruitment and retention of nursing staff.

Apart from the acute patients, who in real terms were few in number, and the long-stay patients just referred to, the third component in St Fintan's comprised approximately twenty older male patients for whom nursing-home or similar accommodation should be sought. The elderly female patients had all left St Fintan's Hospital and were now in St Brigid's Hospital, Shaen or St Vincent's Hospital, Mountmellick in addition to other care centres for the elderly in the catchment area.

Having inspected the shortly-to-be-completed psychiatric unit in Portlaoise General Hospital and noted the self-contained nature of the six-bed sub-unit for older patients, the Inspectorate would recommend that the unit be occupied by the psychiatry of later life services as soon as it is completed in order to establish the psychiatric presence in the unit.

There were fifty-nine non-voluntary admissions to St Fintan's Hospital in 2001. Fourteen non-voluntary patients had their status re-graded to voluntary during their period of hospitalisation. Ten patients admitted as voluntary were re-graded to non-voluntary status. The non-voluntary admission order in respect of one patient was extended during the year. Documentary procedures relating to non-voluntary admissions in this service were satisfactory. Thirty-four patients took their own discharge from the hospital against medical

advice in 2001. Appropriate follow-up procedures were in place for all patients, if deemed appropriate.

Four complaints to the local complaints officer and twenty-one requests under the Freedom of Information Act were recorded during 2001. All appeared to have been dealt with satisfactorily. There were no research projects governed by the Clinical Trials Act 1987 — 1990 undertaken in the Laois/Offaly service in 2001. There were seventeen recorded accidents to patients and six recorded accidents to staff in this service in 2001. Six of the accidents resulted in serious injury. There were three recorded assaults on patients and nine recorded assaults on staff during the year. Six of the staff assaults required further medical intervention.

There were forty-three episodes of seclusion, involving nineteen patients, in St Fintan's Hospital in 2001. There had been thirteen episodes of seclusion, involving five patients, from January 2002 to the date of inspection. Access to the seclusion rooms was through the hospital ward. The room furnishings were adequate and there was reasonable privacy for patients, but the rooms were not structurally appropriate. A seclusion register was maintained, with the full signature of the authorising medical officer being entered. Fifteen-minute nursing observations of all patients placed in seclusion were appropriately recorded. A policy and procedure relating to seclusion was available for staff information and reference.

Health and safety statements were all reviewed in this service in 2001 and site-specific safety statements were available in each clinical location. A health and safety committee met on a two to three monthly basis and appropriate minutes of all meetings were kept. While the management team met daily on an informal basis, more formalised management meetings should take place monthly or bi-monthly and appropriate minutes kept. There was a formal induction process for all non-consultant hospital doctors and a comprehensive postgraduate in-service training manual was available. Appropriate training in CPR, safe lifting techniques, the handling of loads, and the management and control of aggression and violence was ongoing for all staff in this service. The system for reporting and documenting incidents and accidents appeared to be satisfactory.

There was a written protocol, dated June 2000, relating to ECT treatment. Eleven patients were prescribed this treatment at St Fintan's Hospital in 2001. The consent form in use was satisfactory. A named consultant was responsible for ECT procedures and there was an appropriate induction process for all new doctors. The Inspectorate recommends that the ECT nursing checklist be reviewed, updated and amended to include post-ECT observations.

There was an undated policy and procedure document relating to patients absent without official leave. This policy should be reviewed and should state clearly who has responsibility for the return of such patients, who is to take charge of the procedure, how a local search is organised and who leads same, when and by whom contact is made with the Gardaí and when and by whom patients' relatives are informed.

Emergency resuscitation boxes were available in each ward area and were sent to the pharmacy on a monthly basis. The Inspectorate suggests that emergency resuscitation trolleys be placed in strategic wards and an appropriate system of checking all emergency equipment to ensure it is in working order, and all emergency medications to ensure they are within date, be put in place and records of all checks maintained. Checks should be made on a weekly basis.

A selection of medical notes was examined. Patients' names were clearly recorded on each continuation page and each newly admitted patient had a full medical evaluation, including comprehensive admission notes, mental state examination, physical examination and a clear and immediate management plan. The overall standard of note taking was variable. Some notes recorded the assessment and the physical examination on appropriate sheets (MR2 and MR3), while in other notes these examinations were recorded on the continuation pages rather than on the appropriate sheets. All of this required review as one standard system should be used. There was considerable storage of loose clinical material within files. Some of the larger files had loose pages containing clinical documentation. Risks associated with back pockets and loose pages include delay in accessing pertinent information and lost or misfiled information. No instructions were provided on the filing of documentation within the record. The standard information form issued on the day of discharge and the discharge summaries were accessible within the file and were satisfactory.

Notices of patients' rights under the Mental Treatment Act, 1945 were prominently displayed at all locations. There was no hospital brochure for patients giving details of hospital services. Preparation of such a brochure should be considered. There was a smoking policy for the entire service, but this was not rigidly enforced at some locations. There was a need for a dedicated smoking room in the male admission unit. There was evidence of smoking in the sitting rooms and bedrooms. Tobacco products were not issued to patients from ward stock. The smoking policy appeared to be more closely adhered to in the female admission unit than in the other wards. A draft policy document on hospital maintenance charges was under active consideration at the time of this inspection. The draft explanatory leaflet on hospital charges and the intention of service providers to ensure that all patients were informed of such charges were welcome initiatives. Procedures should be put in place to elicit feedback from patients and their families on service provision.

The management of this service was reviewing and updating all policies and procedures and guidelines in accordance with service needs. In order to reduce risk, each guideline, policy or protocol should have a multi-disciplinary focus and a central file of current and superseded policies should be maintained. All clinical and administrative policies and guidelines should be in separate folders, dated and indexed. Guidance on the management of illicit drug use and drug-related incidents, setting out action to be taken on suspicion of illicit drug use or supply and guidelines for staff on search and confiscation of illicit drugs or dangerous weapons, would be included in the revised policy and procedure manual.

The number of episodes of one-to-one special nursing supervision had reduced considerably in this service in recent years. Twenty-one patients were placed on special nursing supervision and there were 372 spans of supervision during 2001. Some of this supervision took place in the local general hospital. The medical preparations policy in Male Unit 6 was dated 1988. This needed review and updating. The standard of prescription writing in the rehabilitation ward was reasonably satisfactory. In other areas the standard was variable. The signature of the prescriber should be given in full and each prescription should be signed and dated individually. The discontinuation column should contain one signature and one date for each drug discontinued. There is an increased risk factor of drug error if discontinued prescriptions are greater in number than current prescriptions, as was the case in a number of instances. The legibility of individual prescriptions was satisfactory.

Ongoing training should be provided for all nursing staff on the use of an appropriate nurse-care planning system. A primary nurse-care system was put in place in 2001, with each patient allocated a nurse directly responsible for their care on a day-to-day basis. The primary nurse should be delegated responsibility for all nurse-care planning documentation in relation to patients in their care and for the presentation of clinical aspects of the patients' condition at all multi-disciplinary review meetings. It is recommended that the nursing records be audited as to standard of record keeping and to identify areas for improvement and staff development. The records should reflect the involvement of patients in planning and making choices and decisions about their own care and treatment. Greater correlation is required between the nursing interventions as set out in the care plan and the nursing notes.

Patients interviewed during this inspection were satisfied with the courtesy and helpfulness of the staff and with the admission process. All reported having been met by nursing staff on admission and introduced to the nursing and medical staff. Patients complained about the lack of activities at ward level, particularly at weekends, reporting that they found their time on the ward long and boring. Patients commented on the need for improved hygiene in bathrooms and for redecoration of some units. Patients were aware that information on their rights under the Mental Treatment Act, 1945 and on the local hospital complaints procedure was publicly displayed. However, they reported that no staff member had explained these rights to them.

Patients reported that the sleeping arrangements at St Fintan's were satisfactory. Patients had access to a bath or shower when requested, or within a reasonable time of asking. One patient complained that the bathroom doors were left open to wandering patients. One patient reported that facilities to meet religious and spiritual needs could be improved, although patients were satisfied with the services provided. All patients complained about the inadequate heating in the dormitories and one patient reported that the heating system was malfunctioning for two weeks prior to this inspection. The heating system in the other wards was satisfactory. All patients were satisfied with the quality and quantity of food provided and with seating arrangements in the dining room.

Patients were satisfied with their consultant psychiatrists and junior doctors. All reported having been given reasonable information about the nature of their medical condition,

including medication and treatment, and having understood the explanations given. When asked whether there was a nurse with primary responsibility for their care, all patients named an individual nurse. All were aware that an individual care plan had been prepared for them and reported adequate contact with nursing staff, who listened to their anxieties and queries about treatment and made genuine attempts to answer same. None of the patients had seen a social worker or a psychologist during their period of hospitalisation.

When asked what could be done to improve facilities, patients responded that they would like to see improved bathroom facilities, more daily and weekend activities, improvement in the overall décor and more confidential consultations with individual consultants and doctors rather than meeting all members of the multi-disciplinary team simultaneously.

RECOMMENDATIONS

It is recommended that:—

1. Acute in-patient services be re-located from St Fintan’s Hospital to the new purpose-built psychiatric unit at Portlaoise General Hospital as soon as possible.
2. The department of later-life psychiatry have immediate access to beds in the section allocated to it in the new assessment unit at Portlaoise General Hospital.
3. High-support residential accommodation be provided for patients currently residing in the rehabilitation unit and admission ward of St Fintan’s Hospital.

LONGFORD/WESTMEATH MENTAL HEALTH SERVICE — 2002 INSPECTION

INSPECTED ON 16 APRIL, 2002

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 95,200 was divided into three sectors as follows:

Sector	Population
Mullingar	41,126
Longford	30,138
Athlone	23,936

IN-PATIENT CARE

In-Patient care was provided at St Loman’s Hospital, Mullingar, which had 184 beds in four male and three female wards.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	1	19	18	3	4	45	24.9
3 to 12 Months	—	—	6	6	4	—	16	8.8
1 to 5 Years	—	—	12	8	7	10	37	20.4
Over 5 Years	—	—	8	25	21	29	83	45.9
All Lengths of Stay	—	1	45	57	35	43	181	100
% of Total	—	0.6	24.9	31.4	19.3	23.8	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
6	104	1	30	14	2
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
7	7	2	8	—	181

Status of In-Patients on the date of inspection 2002

Status	Male	Female	Total
Voluntary	81	56	137
Temporary	12	7	19
P.U.M.	3	1	4
Ward of Court	9	1	10
Total	105	65	170

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
844	8.9	206	24.4	86.4	13.6	847	16

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of Persons Attending
Day Hospitals	3	Not specified	395
Day Centres	4	Not specified	174
Out-patient clinics	5	Not specified	1,263

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
8	34	3	25	3	38

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
13	28	208	120.5	17.5

COST

The cost of the Longford/Westmeath Mental Health Service was €13 million in 2001.

GENERAL COMMENTS

Among the changes evident to the Inspectorate on this visit was the completion of internal structural alteration and extensive refurbishment of one wing of the admission unit, which was ready to accept the return of male admission patients currently housed in the female admission unit, while female admission patients were accommodated in the main St Loman’s building. Also, a consultant in later-life psychiatry had taken up duty and a substance-abuse consultant psychiatrist had been appointed to the service. There was also an expansion of the multidisciplinary teams inclusive of social work and occupational therapy staff. Apart from these advances, there had been no major changes in this service since the inspection of 2001.

The Longford/Westmeath service still centred very much on St Loman’s Hospital in Mullingar, though there were premises in each of the three sectors, at Athlone, Longford and Mullingar. The Athlone premises was extremely limited and, although there were plans for major developments on this site for general medical and social services, including a psychiatric component, none of this had yet been undertaken. In the case of Longford and Mullingar, it was the Inspectorate’s impression that the day hospital facilities and community mental health centres were under-utilised, and perhaps under-appreciated as to their true potential, in both locations. In Mullingar, in particular, it was felt that the day centre and out-patient activities, which took place in the community mental health centre, should be located elsewhere to enable day hospital activity to cater for more severely ill patients. More active participation in the care of such patients should fulfil the under-utilised potential of these community facilities and reduce the very high admission rate to St Loman’s Hospital. There had been an increase in the number of psychologists, social workers and occupational therapists employed in the service, but little occupational activity took place in St Loman’s, for either the acute or long-stay patients.

On the day of inspection there were 170 patients in St Loman’s Hospital. Of these, thirty-five were from Co Meath, which was formerly part of the catchment area of St Loman’s. These were all long-stay and mostly older patients. Fifty-two per cent of St Loman’s residents were aged over sixty-five years, and thirty-four per cent of them aged over seventy-five years. Most of them were located in the three-ward St Brigid’s block. These

patients required services for the elderly, rather than those of active psychiatry; it was understood that their care would be entrusted to the new later-life psychiatry service in association with the generic medical services for the elderly in Mullingar. The Inspectorate has repeatedly advocated that they be de-designated from the psychiatric register. The newly established later-life psychiatry service lacked a basic infrastructure. A former activation centre in the St Brigid's block had been made available to it but, clearly, a community-based location would be far preferable. There were no designated acute assessment beds for this service; its access to continuing care other than at St Brigid's, had not been provided. Nor was there any immediate prospect of an appropriate day hospital premises in a general hospital setting.

St Loman's long-stay patients required appropriate occupational or activation services. With the exception of a small number who attended the centre in the former nurses' home, too many spent their day purposelessly in their wards. The Inspectorate remained concerned about conditions in St Edna's ward, despite the improvements that had been brought about in recent years, and felt that it should play no role in modern psychiatric care. Accommodation was of an antiquated nature and the entire milieu lacked any therapeutic purpose. Five of the patients here were from the Laois/Offaly service, having been sent here for containment purposes. None of them, including one who had arrived two months previously, had been visited by the Laois/Offaly medical staff, who should retain some responsibility for their ongoing care. It was disappointing to hear also that patients in the St Maria Goretti ward in St Brigid's block had not been down to the newly renovated veranda area this year. Patients in this first-floor ward should have access to fresh air as part of their care programme. A lift was provided to help the less ambulant patients access to the ground floor.

There were difficulties relating to the removal of asbestos materials in two of the wards remaining in St Loman's, St Anne's and St Clare's, and these were to be vacated so that the asbestos could be removed in safety and the ensuing refurbishment carried out. Because of this, the two wards would, in sequence, be moved to the shortly-to-be-vacated male admission ward until their respective wards in St Loman's were remedied of this problem. This meant that the impending refurbishment of the second ward in the admission unit would not proceed until St Anne's and St Clare's were relocated to their refurbished wards in St Loman's. The refurbishment of the male admission ward had been an expensive project — figures of approximately €1.6 million were quoted — and it was anticipated that the figure for the female unit would be even higher. All of this made one hope that the provision of an acute admission unit for this service in the Longford/Westmeath General Hospital in Mullingar would not be long delayed. Another reason for this aspiration was that patients in St Loman's prescribed ECT treatment had to be brought, with accompanying staff, to the general hospital as the anaesthetists would not undertake this treatment in St Loman's, regarding the facilities there as inadequate for this purpose.

There did not appear to be a coherent admission policy on in-patient care in this service. As a consequence, there was very little appropriate assessment of patients presenting for admission to St Loman's. Patients did not appear to be diverted to the mental health

centres. It appeared, from what the Inspectorate could gather, that junior doctors did not confer with consultants in relation to making admission decisions, with the result that a patient presenting for admission was more likely to be admitted than to be referred to more appropriate services. As a result, the admission rate, at over eight per 1,000 of the population, was one of the highest in the country. The knock-on effects of this were that beds in the admission units were often unavailable and patients in these units were sometimes moved to other wards in St Loman's, including St Edna's (there had been fifteen such moves from January 2001 to the date of this inspection) to make room for those being admitted.

Finally, it was noteworthy that, of the seven wards in St Loman's Hospital, all but one was locked.

The substantial reduction in the number of episodes of seclusion within this service, from twenty-three in 1999 to one in 2001, was noted. An appropriate seclusion register was maintained. The seclusion policy and procedure was reviewed in January 2002 for inclusion in the up-dated policy and procedure manual. At the time of inspection, this policy and procedure was not available in the clinical areas. Fifteen patients were placed on one-nurse-to-one-patient, special supervision during the year and there were 386 spans of special nursing supervision of ten hours or more. Special nursing supervision was initiated and discontinued on the instructions of medical staff. On this inspection it was noted that some patients not on special nursing supervision were under 'close observation'. No criteria or account of what this entailed was made clear. The risk associated with this was that individual perceptions of close observation were likely to vary and, at times, may not have been sufficient. There was a need for a policy and procedure available in each area, setting out specific levels of observation. The Inspectorate suggested three levels of observation:

- general observation, as applicable to all patients in the ward, and which was an integral part of a nurse's role, where individual nurses shared the responsibility for observing patients and communicating information;
- prescribed recorded observation, with one nurse designated to maintain a periodic awareness of a patient's precise location. This was an organised plan to ensure periodic observation, in which the nurse checked the patient's location and behaviour; and
- special nursing supervision, with one-to-one special observation and supervision of a patient by a qualified nurse as directed by a consultant psychiatrist.

Nineteen patients were prescribed ECT in 2001. The treatment was administered to patients in the day ward of Longford/Westmeath General Hospital. A policy and procedure was under review for ECT. The consent form in use was satisfactory. There was an induction process for all new doctors and a named consultant responsible for the ECT clinic. A new pre- and post-ECT checklist was available and a nurse trained in basic life support was rostered for duty in the recovery room following the ECT procedure.

A written policy and procedure for missing or absconding patients was reviewed in January 2002. This document indicated the procedure to be followed once a patient was noted missing from the ward areas, and set out responsibilities of various personnel. The revised policy should state clearly who was to take charge of AWOL procedure, how a local search was to be organised, who was to contact the Gardaí, who was to contact the patient's relatives, and who was to take charge of the decision-making process once the patient was located.

There were no research projects governed by the Clinical Trials Act 1987-1990 undertaken in this service in 2001. Three requests for information under the Freedom of Information Act were made in 2001. There was one complaint made to the local Complaints Manager during the year. Information relating to the local complaints procedure was prominently displayed at each clinical location, which also contained an information notice on patients' rights under the Mental Treatment Act, 1945. It was not clear whether these notices were ever brought to the attention of patients. Information given by staff members to patients relating to the complaints procedure or their rights under the Mental Treatment Act, 1945 should be recorded in the patients' notes.

There were 147 accidents to patients and eighteen accidents to staff in 2001. Ten of the accidents to patients and six of those to staff were deemed serious. There were fifty-three assaults on patients by other patients, and thirty assaults on staff. Two of the patient assaults were deemed serious; twenty-seven of the staff assaults and twenty-one of the patient assaults resulted in mild injuries, such as scratches or bruising.

One hundred and fifteen patients were admitted on temporary admission orders in 2001 and fourteen patients had their temporary admission orders extended. Eleven patients admitted as voluntary patients were regraded to involuntary status during their hospital stay. Thirty-one patients admitted as involuntary patients were regraded to voluntary status. All temporary admission orders were reviewed as part of this inspection and were found to be satisfactory. Twenty-seven patients were lodged overnight but were not formally admitted. One hundred and thirty-six 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 planning checklist, including a discharge information leaflet and a take-home medication leaflet was under review by a local sub-committee at the time of inspection. The Inspectorate looks forward to reviewing the implementation of these procedures on the next visit of inspection.

The written policy for ordering, prescribing, storing and administering medicines was under review. Noted in one ward was a policy dated 1991 and, in another ward, a policy dated 1996; the review was therefore timely. The leaflet, *Taking Medication*, setting out general information for patients and relatives on prescribed medicines was welcomed. The standard of individual prescription writing varied. Each prescription should be signed and dated individually and the discontinuation column should contain one signature and one date for each prescription. Similarly, the drug administration-recording card should have

provision for the administering nurse's signature in full and the time of administration should be clearly stated.

A new clinical case file had been introduced since the last inspection. However, most of the files examined in the clinical areas were of the older type. A more rapid changeover to the new filing system was recommended. Each newly-admitted patient had a formal medical evaluation, which included the taking of comprehensive admission notes, mental state examination, physical examination and clear immediate management plan was set out in the new assessment form which, in all cases examined, was completed satisfactorily. Copies of discharge summaries were easily available within the clinical notes. There was provision for the recording of the patient's name and date of birth on each continuation page, but this was not always recorded. The signature of the doctor obtaining the information was, in some instances, illegible. Designation was not always recorded. Ideally, the doctor should write his or her name in capitals and sign the entry and then record his or her designation. This would enable identification of the practitioner in the future. While the date of entry in the notes was recorded, time of assessment was not. Recording of time is useful in determining any delays in assessment or treatment.

The management team of this service met on a monthly basis and detailed minutes of meetings were kept. In addition, joint meetings with the nearby Laois/Offaly mental health service were organised on a quarterly basis and minutes of all meetings were kept. These minutes were available to the Inspectorate as part of this inspection.

There was no fire committee at the hospital, but the facilities were inspected by the Board's fire officer. A safety committee was in existence, but the Inspectorate was unable to determine the date of its last meeting. There was a generic safety statement dated 1994 in each of the clinical areas. Records of periodic safety audits were not available in the ward areas. It was suggested that all safety statements be reviewed and updated and copies of safety audits be kept locally. Designated smoking areas were set aside in all wards, but these were not always clearly signposted. There was evidence of smoking in some bedrooms, a practice that should be discouraged. A number of patients were noted smoking on corridors and in non-designated areas. Staff should ensure that the smoking policy is adhered to. A fire committee should meet regularly and keep appropriate recordings of such meetings. This can be incorporated into the safety committee. There were training courses for all staff in fire precaution techniques and evacuation procedures. In all residential areas, there should be regular checking and inspection of all fire equipment, particularly in community residences. In one residence, it was noted that the fire equipment was last checked in the year 2000. Periodic fire awareness and evacuation drills should be organised for all persons residing in community residences.

While all staff were aware of their responsibility in relation to personal safety and the safety of patients and colleagues, it was noted on this inspection that very few were wearing the personal alarms provided. A written policy, dated 1996, on the use of the personal safety equipment was not being adhered to. No records were kept of the testing of the alarm system, although the Inspectorate was told that this system was checked on a fortnightly basis. Similarly, records should be kept of all times the alarm is activated, stating

the reason and the action taken by staff. Training courses for staff on the management of violence and aggression were organised on an ongoing basis, enabling all staff to attend on rotation. Emergency resuscitation trolleys or trays were stored at appropriate locations throughout the service and were checked regularly. The system of reporting and documenting incidents, accidents and assaults was satisfactory.

The patients' money management systems inspected appeared satisfactory, but a system should be in place for informing patients on hospital charges. A written money-management policy should be available in each clinical area for staff information and reference. Similarly, a local record of the independent checking and auditing of patients' monies held by staff at ward level should be kept. Periodic checking of dry foodstuffs in ward stores should also be undertaken, as it was noticed that there was an accumulation of certain foodstuffs way beyond the weekly needs of patients accommodated in certain units.

At the time of inspection, all policies and procedures relating to the care of patients were under review and the management team intended to issue revised policies and procedures which would include guidance notes on the management of illicit drug or drug-related incidents, setting out the action to be taken on suspicion of illicit drug use or supply, policy for staff to search and confiscate illicit drugs, alcohol or dangerous substances, and arrangements for disposal of same.

The standard of nursing records in St Loman's Hospital was variable. A new nurse care planning system had been introduced in the two admission units and this was welcomed. In all other locations, basic nursing notes were recorded and were filed loosely in ring binders. When a patient was discharged the notes were transferred to the clinical file. A considerable number of loose pages were noted in the ring binders. Risks associated with this practice included misfiled or lost clinical information. Some care plans were completed satisfactorily and the nursing records reflected the involvement of patients in planning and making choices and decisions about their care and treatment. Other notes were nurse-led rather than patient-focussed. This variable standard was understandable when a new system was being introduced, and it highlighted the need for ongoing education of staff in relation to the nurse care planning system to ensure uniformity of approach. All entries in nursing records should confirm how a patient settled in the ward at the end of their first day of hospitalisation. All records should be readable on photocopies and should contain the time of entry and the nurse's full signature. The patient's name and date of birth was appropriately recorded on all nursing documentation examined. The Inspectorate welcomed the audit of alcohol-related admissions to St Loman's and St Fintan's hospitals. The report was in draft form for submission to the catchment area management team for consideration of its findings.

On a number of wards, patients were observed sitting in lounges or in bedroom areas, with little or no discernible focus of activity and no obvious interaction with staff. In our interviews with patients they spoke of the need for more recreational and diversional activities, including a better variety of reading matter, and cooking or craft activities, as all too often the only recreational and diversional activities available were smoking and watching television. Patients interviewed as part of this inspection were generally satisfied

with the courtesy and helpfulness of staff. All reported being informed of the name of the consultant responsible for their care and all reported reasonable access to their consultant while hospitalised. When asked whether they had been shown around the ward on admission or within a reasonable time thereafter, all patients indicated a familiarity with the ward environment as they had been hospitalised previously in St Loman’s Hospital. Patients were not offered an information booklet with pertinent information about the hospital, but all were appreciative of the health information literature available in each ward area. Three patients reported that they were not allowed wear their own clothes for a number of days after their admission. One patient was given a full explanation for this, one was given no explanation and one did not want an explanation.

Patients were not aware of their rights under the Mental Treatment Act, 1945. One patient was aware of the notices in the ward area but had not read them; one patient was aware of the detailed hospital complaints procedures. Patients were generally satisfied with the variety of smoking and non-smoking areas provided in the clinical locations. All patients reported general satisfaction with the service provided by their consultant psychiatrist and junior doctor. Patients were generally satisfied with the heating, overall cleanliness of dayroom, bathroom and toilet facilities, facilities for visitors, quality and quantity of food provided and seating arrangements in the dining room. One patient complained that the heating system was too warm and two patients complained about the inadequate facilities for visitors. One patient was dissatisfied with the bathroom and toilet facilities. All patients were satisfied with the sleeping arrangements, access to bath or shower, storage space for clothing and personal belongings, and facilities to meet spiritual and religious needs. One patient on a second admission to St Loman’s Hospital reported that he had not been given reasonable information on the nature of his medical condition, including medication and treatment. All other patients interviewed reported general satisfaction and understanding of all explanations given to them by their consultant and medical staff. All patients interviewed were on prescribed medication and reported that its therapeutic effects, and possible side effects, had been fully explained to them by the medical staff. All were satisfied that the nursing staff listened to their anxieties and queries about treatment and made genuine attempts to answer them. Patients were not aware if a nurse was assigned with primary responsibility for their care or if they had a nursing care plan. All patients reported having seen a social worker during their period of hospitalisation. All were satisfied with the information on social welfare, old-age pensions and other benefits.

When asked what improvements they would like to see in service provision, one patient replied, ‘Nothing in particular’. Other patients emphasised that the day was long and boring and there was a need for enhanced occupational, recreational and diversional therapies. One patient reported inadequate washing facilities for personal clothing in the ward area.

RECOMMENDATIONS

It is recommended that:—

1. An acute psychiatric unit be provided in Longford/Westmeath General Hospital as soon as possible.

2. St Brigid's Block of St Loman's Hospital be de-designated and identified as a specialist unit for older persons.
3. More use be made of the Mullingar and Longford day hospitals for acute purposes.
4. A written protocol on the locking of external ward doors be available at each location.
5. A smoking policy be introduced with appropriate signposting of designated smoking areas, and that smoking in bed areas, on corridors, and in dining rooms be discouraged.
6. The fire-safety equipment in all community residences be checked at least annually to ensure it is in working order.
7. All clinical files currently in use be changed over to the new system as soon as possible.
8. Appropriate occupational, recreational and diversional activities be provided for all of the patients in St Loman's Hospital.
9. Appropriate assessment and day hospital facilities be provided for the developing psychiatry of later life services.
10. A written policy and procedure setting out specific levels of nursing observation be made available in each ward.
11. A revised policy and procedure on the storage, prescription, administration and recording of medicinal products be made available in each clinical area.
12. The generic safety statement be revised and updated and site-specific safety statements which include copies of all local safety audits and actions taken or required to address identified hazards be made available in each clinical area.

CHAPTER FOUR

Mid-Western Health Board

CLARE MENTAL HEALTH SERVICE — 2002 INSPECTION

INSPECTED ON 29 AUGUST, 2002

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 94,006 was divided into four sectors as follows:

Sector	Population
East Clare	28,115
West Clare	19,293
North Clare	17,093
South Clare	29,505

IN-PATIENT CARE

In-Patient care was provided at Our Lady’s Hospital, Ennis and at the acute psychiatric unit in Ennis General Hospital which opened on 8.12.2001.

Age and Length of Stay of all Patients at 31.12.01 (Ennis General Hospital)

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	3	26	8	9	—	46	100
3 to 12 Months	—	—	—	—	—	—	—	—
1 to 5 Years	—	—	—	—	—	—	—	—
Over 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	3	26	8	9	—	46	100
% of Total	—	6.52	56.52	17.39	19.56	—	100	

Age and Length of Stay of all Patients at 31.12.01 (Our Lady’s Hospital, Ennis)

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	—	—	1	—	—	1	0.68
3 to 12 Months	—	—	1	4	—	—	5	3.40
1 to 5 Years	—	—	4	26	10	5	45	30.61
Over 5 Years	—	—	8	42	32	14	96	65.31
All Lengths of Stay	—	—	13	73	42	19	147	100
% of Total	—	—	8.84	49.66	28.57	12.93	100	

In-Patient Population Diagnosis at (31.12.01) (Ennis General Hospital)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	12	—	11	7	2
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
1	7	4	1	1	46

In-Patient Population Diagnosis at (31.12.01) (Our Lady’s Hospital, Ennis)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
5	72	3	15	8	2
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
3	4	4	31	—	147

Status of In-Patients on the date of inspection 2002 — Acute Unit, Ennis General Hospital

Status	Male	Female	Total
Voluntary	10	17	27
Temporary	7	8	15
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	17	25	42

ADMISSIONS/DISCHARGES AND DEATHS IN 2001 — (Our Lady’s Hospital and Ennis General Hospital)

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
502	5.3	91	18.12	85.8	14.2	494	5

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of Persons Attending
Day Hospitals	4	49	883
Day Centres	3	70	174
Out-patient clinics	12	565*	968

*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
6	26	5	32	2	29

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
12	12.5	194	51	14.43

COST

The cost of the Clare Mental Health Service was €17.3 million in 2001.

GENERAL COMMENTS

Since the 2001 inspection, the Clare mental health service had reached a milestone in the provision of mental health services by the complete closure of Our Lady’s Psychiatric Hospital, Ennis, which opened in the 1860s. This was accomplished by two main endeavours, the resettlement in the community of the longer-stay patients, including those with intellectual disability, and the opening of the psychiatric unit for acute in-patient care in Ennis General Hospital. Clare had become the first service completely to close its psychiatric hospital, although followed at a short interval of time by a similar accomplishment in Cork. Given the complex difficulties associated with closing a hospital in this country, it is appropriate to pay tribute to those who brought it about.

It was also refreshing to report that the senior management of this service, as in the neighbouring Limerick service, appeared to have a clear vision as to the how the service should proceed. Another initiative had been the recent appointment of a full-time specialist consultant-led rehabilitation service. This was all the more appropriate given the number of seriously impaired persons, following many years of institutionalisation, many of whom were now residing in the Orchard Grove housing complex at Ennis.

The acute unit at Ennis General Hospital had been functioning for several months at the time of this inspection and, generally speaking, no major problems had arisen. The Inspectorate had some anxieties, however, concerning the close observation area. This had become a locked area within the unit, contrary to the Inspectorate’s preference for an unlocked close observation area, without a door between it and the unit as a whole. It was felt that, at nine beds, and therefore a sizeable proportion of the unit as a whole, it was too large. A further cause of concern was the civil rights dimension of the close-circuit television camera link to television screens at the nurses’ station, which gave vision into all components of the intensive-care area, i.e., the two three-bed units and the single rooms. Whereas the Inspectorate was prepared to tolerate close-circuit television monitoring of a single room while used for seclusion purposes in the interest of safety, it felt that such monitoring of every component of this area was a serious infringement of privacy.

Unfortunately, persons referred to the psychiatric service at Ennis General Hospital for assessment came directly to this unit, rather than to the A & E department. This, however, was condonable on the basis that the A & E department as currently constituted consisted of little more than one room. However, there are plans for the development and enlargement of the A & E facility and it is hoped that, when this comes about, patients coming for assessment will be filtered through that department. In this context, it was worth mentioning that, similarly with Limerick, a triage nurse had been appointed and was in post to act as a filtering agent for persons so referred, and to deal particularly with those who had attempted suicide. This post was rotated between two staff members and operated until 3.00 a.m., similar to the Limerick situation. Obviously, when the new, enlarged A & E department came into being, it would be important that this nurse be accommodated in the A & E department. It was of note that there was an activation officer employed in the unit and that he was shortly to be joined by a full-time occupational therapist, based in the unit.

As already indicated, the putting in place, quite recently, of a comprehensive and multi-disciplinary rehabilitation team was a major step forward. This team, which was based in Cappahard, would have a major input to the Orchard Grove housing residents and to those in Teach na Beatha, the rehabilitation hostel. The nineteen patients in the Orchard Grove bungalows had significant impairments and deficits, which offered a challenge to this newly established team. The Inspectorate felt that the task might be made easier if these nineteen persons were sub-divided into two smaller groups. In any case, some improvement of the furnishing and floor coverings in the bungalows was to be undertaken, together with the embellishment and upgrading of the external recreation area at the back. The sustained occupational activity needed for some patients had yet to be provided, although they had access on a sessional basis to the adjacent social centre which formed part of the overall RESPOND housing complex.

The consultant in later-life psychiatry had now acquired two nursing staff exclusive to the service. In addition to the acute assessment five-bed facility in the psychiatric unit of Ennis General Hospital, it was understood that, for continuing care purposes, this team had admission rights to Cappahard and Units 5 and 6 of St Joseph's Hospital, Ennis. It was suggested that there was some lack of clarity in relation to jurisdiction and responsibilities in Cappahard and in the two St Joseph's units. As far as Cappahard was concerned, the physical needs of its forty-five patients, most of them older persons, who had been transferred from long-stay residence in the former Our Lady's, were attended to by a local GP for ongoing psychiatric and medical care requirements. However, as far as could be understood, the later-life psychiatry service was available for consultation purposes on referral of these persons, but did not have, appropriately, continuing care responsibilities for them. New patients admitted for continuing care purposes from the specialised service for older persons were looked after by this service. Patients who had grown elderly in community residences and had become frail, needing physical inputs of a specialised kind, should be dealt with by the generic services for the elderly of the county, and not admitted to Cappahard. It appeared that there were ongoing negotiations between the generic elderly services for the county and the psychiatric service on this issue. The rehabilitation service had also been consulted in relation to the desirability of inputs for the Cappahard

residents. In relation to St Joseph's, there was, apparently, an anomalous situation in that one of the two units was under the jurisdiction of the matron of the hospital and staffed by her staff, whereas the other was the responsibility of the psychiatric service. It was suggested to the Inspectorate that the location of administrative responsibility for these two units was a matter that needed to be attended to.

The Inspectorate was impressed that the Ennis Day Hospital had been enlarged to provide staff accommodation so that it might genuinely serve as the sector headquarters for that sector. There did appear to be an outreach attitude on the part of staff in this component of the Clare service, so that care in the community, including home care, was being envisaged for the sector, and a crisis dimension, both on a domiciliary and a referral basis, was being approached. It was unclear to what extent this philosophy and practice existed in the other sectors, i.e., in Shannon, Ennistymon and Kilrush, but the impression was that matters had not progressed in those sectors, either in terms of physical resources or attitude — although Kilrush was possibly well on the way to emulating Ennis in this regard. At any rate, it was important that community-based delivery evolved in this fashion. It should be assisted by the much improved multi-disciplinary nature of the four Clare teams.

Having visited virtually every development of the Clare community services in 2001, including those, which had not yet opened, the Inspectorate limited its community visitation on this inspection to the newly opened Gort Glas high-support residence in Ennis. This appeared to be functioning well, although the Inspectorate would have preferred to see more consistent and pervasive activity programmes for more of the residents, and would also recommend that the large health board insignia, prominently displayed on the front façade and gable end of the building, be removed so that the residence appeared to be a more 'normal' premises, rather than an institution which the health board coat of arms, however impressive, indicated it to be.

It was reported that the newly opened high-support facility for the intellectually disabled in Spanish Point was functioning well and that some of the residents there were already showing some improvement in their social and behavioural characteristics. The high-support facility in Kilrush was operating satisfactorily. It was hoped to visit the premises at Kilrush, Ennistymon and Shannon on the next visit of inspection.

It was understood that there was a difficulty in filling nursing staff vacancies and that a recruiting campaign had been carried out in the Republic of South Africa, with the imminent arrival of future staff members from that country to fill vacancies. However, the nursing establishment for the county was quite generous and, as usual in such situations, it seemed to the Inspectorate that recruitment of non-nursing staff with an improvement in the skill-mix situation would be a more appropriate response.

The Inspectorate was happy to hear that a service catchment area headquarters was to be established in a freestanding building in the former Our Lady's Hospital complex, which had been retained by the mental health service.

There were no recorded episodes of seclusion in the Clare mental health service in 2001. The number of episodes of seclusion for the period 1st January, 2002 to 29th August, 2002 was seventy, involving seventeen patients, in the new psychiatric unit at Ennis General Hospital. A seclusion register was maintained; however, periods of seclusion were not specified in some cases. The medical officers authorising seclusion should use their signature in full on the seclusion register. The policy on the use of seclusion for in-patients was dated 1/9/1998 and required review. Seclusion is the supervised confinement of a patient in a room that was locked to protect the patient and others from significant harm. Its sole aim should be to contain severely disturbed behaviour likely to cause harm to the patient or to others. Seclusion should be used as a last resort and for the shortest possible time. Seclusion should not be used as part of a treatment programme and Section 2.5 and part of Section 1 of the existing policy should be immediately reviewed. Documented reports of nursing observations while patients were placed in seclusion were appropriately recorded. The room used for seclusion provided privacy from other patients, was safe and secure and did not contain anything that could harm the patient or others. The room was adequately furnished and heated, but there may have been some difficulties with ventilation and this required review. There was a need for a regular audit of the use of seclusion.

It was noted in the long-stay elements of the Clare service, just as in those of Limerick, that wards were allocated a weekly ration of cigarettes (in the case of one ward in Limerick, 1,000 cigarettes a week) for which patients did not pay. These cigarettes were distributed at the discretion of nursing staff. The Inspectorate felt strongly that this practice should cease and that health boards should not distribute cigarettes to patients freely; apart from anything else, such a health-damaging activity on the part of a health board might be actionable.

Nine patients were prescribed ECT in the Clare service in 2001. The arrangements for ECT were all satisfactory. There was a dedicated ECT suite, comprising a separate waiting room and recovery room. A named consultant psychiatrist was responsible for the ECT clinic and there was an appropriate induction process for new medical staff. A pre- and post-ECT nursing checklist was appropriately recorded and the consent form in use was satisfactory. A dedicated ECT nurse was trained in basic life support. The pre- and post-ECT nursing checklists were very comprehensive. There was also a form for checking the clinical outcome by asking the patient how they felt compared with how they felt before ECT at one-week, one-month, and six-month intervals after treatment, and asking the doctor's opinion of the therapeutic response and cognitive outcome.

All policies, procedures and clinical guidelines were under review at the time of this inspection. While a cover sheet was available regarding the policies and appropriate authorisation for implementation, the service should consider providing an individual cover sheet, detailing reference numbers, authors of the policy document, monitoring procedures, as well as detailing the reference documentation used as the evidence base for the policy. Some confusion existed between a policy and a procedure and consideration should be given to integrating the policy and procedure into one document where two

separate documents existed, i.e., a policy and procedure document, and the use of a reference numbering system should be considered. Policies were required on the locking of external or internal ward doors and on the guidance and management of illicit drug use or drug related incidents, setting out the action to be taken on suspicion of illicit drug use or supply. There should be a policy for staff to search and confiscate illicit drugs and arrangements with the Gardaí for the disposal of illicit drugs or articles.

Thirty-eight patients were placed on one-nurse-to-one-patient special nursing supervision and there were 729 spans of special nursing supervision during 2001.

There were five complaints made to the local complaints/appeals manager and six requests under the Freedom of Information Act. All appeared to have been dealt with satisfactorily. There were no research projects undertaken in the Clare mental health service last year governed by the Clinical Trials Act 1987-1990.

Written information for patients and relatives under the Mental Treatment Act, 1945 and amending legislation should be available for the information of patients and their relatives. The giving of information on rights to detained patients should be adequately recorded in the patients' case notes. A standardised form should be used to record that information had been given to patients about their legal position. The form should have space for recording the name of the person giving the information, the date the information was given, whether the patient understood the information, subsequent attempts to give that information, and a planned date for the next attempt. It was recognised there were difficulties in explaining legal matters to patients whose mental state might preclude the understanding or retention of such information. It was important that a patient's rights were explained as far as possible in a way the patient understood. There should be written procedures for dealing with complaints from patients and families, and information should be readily available for patients and relatives on how to make verbal or written complaints or suggestions on the improvement of service provision. Notices to this effect should be prominently displayed in every treatment location, with the name of the local complaints officer. Written guidelines on the handling of complaints alleging abuse, ill-treatment or neglect of patients in the mental health service should be available and these should be known to all staff members and available on request to patients and families. In addition, notices communicating this information should be prominently displayed in in-patient centres.

Forty-five patients were admitted on involuntary, temporary admission orders in 2001 and there were no extensions of involuntary admission orders during the year. There were twenty-six involuntary PUM admissions to this service in 2001. Seven patients admitted as involuntary patients were regraded to voluntary status during the course of their hospitalisation. Eight patients admitted as voluntary patients were regraded to involuntary status while hospitalised. Eight patients took their own discharge from the service in 2001 and appropriate procedures were in place for follow up if deemed clinically appropriate. There were five deaths at Our Lady's Hospital during the year, all from natural causes. Ten patients became new long-stay (over one year continuous hospitalisation and less than five years) patients in 2001, and two of these were aged sixty-five years or over.

There were nineteen recorded accidents to patients and four recorded accidents to staff in 2001. Eight of the patients' accidents were deemed serious. There were five recorded assaults on patients by other patients, all resulting in no detectable injury. There were nine recorded assaults on staff, seven resulting in mild injury such as scratching or bruising, and two were deemed serious.

A written drugs policy and procedure was available for staff information and reference. This policy was under review at the time of this inspection. A number of individual prescriptions, picked at random, were examined. There was a moderate risk factor of administering incorrect medication, as a small number of scripted prescriptions were difficult to read. All other prescriptions were satisfactory. All prescriptions were dated individually and signed. The full signature of the person prescribing was appropriately recorded on the prescription cards. There was provision for recording drug allergies within the documentation to ensure that information was readily available to staff. Discontinued drugs were signed off using the discontinuation column. There was an increased risk factor of drug error on a small number of prescription cards where the number of discontinued prescriptions exceeded current prescriptions. These cards should be rewritten.

Not all new staff underwent a formal induction process. Induction could be informal and did not always cover important issues. All new employees should be required to attend a formal induction process, formulated within an agreed framework. Records should be kept of the induction process, with the names of those participating, content of induction course and name of staff assigned to conduct various parts of the induction process.

Two patients were interviewed to assess their view of the psychiatric services provided. The Inspectorate was satisfied that the totally negative responses received from one patient were due to the fact of involuntary detention and, from observation of this patient, it was felt that involuntary detention was warranted. This particular patient did make suggestions as to how the services could be improved, and they were as follows: single bedrooms, more access to tea and coffee, more privacy, more access to outside, more day trips, less harassment. A complaint, however, was the assertion that there was no proper talking through of problems.

The second patient was of voluntary status and was on his third admission to the unit. He was quite pleased with the interaction with the medical and nursing staff. He found them very helpful and was always treated with the utmost privacy and dignity. He was very positive towards the general ambience of the wards, hygiene, décor, etc., and was very pleased with the quality and quantity of food provided. His medical condition was adequately explained to him, as were the medications prescribed and their side effects. He would appreciate written information. He had not heard of a nursing care plan. He was very appreciative of the activities offered, particularly the occupational department and the gym facilities. As to suggestions as to how the services could be improved, he said he was very satisfied with things as they were. He was very pleased with the new general hospital unit, saying it was more personal and visitor-friendly, with ample options for therapeutic activities.

RECOMMENDATIONS

It is recommended that:—

- 1. Similarly to the recent extension of the Ennis day hospital/sector headquarters/community mental health centre for that Sector, equivalent improvements be effected in the sector premises in Shannon, Kilrush and Ennistymon to enable sector headquarters and acute day hospital activity, together with outreach / crisis activity, to take place in and from these sector premises.
- 2. Some review and revision be given to the locked ‘secure unit within the unit’ in the acute unit at Ennis General Hospital and that closed-circuit TV surveillance be restricted to the seclusion rooms when a patient was in seclusion.
- 3. Thought be given to rationalising the numbers of patients cared for as one unit in the existing Orchard Grove housing premises.
- 4. The practice of distributing cigarettes to long-stay patients be discontinued.

LIMERICK MENTAL HEALTH SERVICE — 2002 INSPECTION

INSPECTED ON 28 AUGUST, 2002

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 165,042 was divided into five sectors as follows:

Sector	Population
North City	29,242
South-East and Limerick City	41,561
South-West City, Adare and Croom	39,476
Newcastle West (Rural)	32,823
Kilmallock (Rural)	21,940

IN-PATIENT CARE

In-Patient care was provided at St Joseph’s Hospital, Limerick, which had 155 beds in three male, two female and two integrated wards, and at the fifty-bed acute psychiatric unit in Limerick Regional Hospital.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	1	17	22	2	6	48	25.1
3 to 12 Months	—	1	4	7	1	—	13	6.8
1 to 5 Years	—	—	9	14	8	6	37	19.4
Over 5 Years	—	—	7	40	26	20	93	48.7
All Lengths of Stay	—	2	37	83	37	32	191	100
% of Total	—	1.0	19.4	43.5	19.4	16.7	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
11	87	1	24	19	9
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
2	5	2	28	3	191

Status of In-Patients on the date of inspection 2002 — Acute Unit

Status	Male	Female	Total
Voluntary	17	18	35
Temporary	5	8	13
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	22	26	48

Status of In-Patients on the date of inspection 2002 — St Joseph’s Hospital

Status	Male	Female	Total
Voluntary	82	55	137
Temporary	7	2	9
P.U.M.	4	3	7
Ward of Court	1	2	3
Total	94	62	156

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
768	4.65	189	24.6	86.2	13.8	813	13

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of Persons Attending
Day Hospitals	5	125	1,462
Day Centres	5	105	193
Out-patient clinics	22	1,374*	2,090

*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
5	30	6	40	4	76

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
13	19	277	54.72	12

COST

The cost of the Limerick Mental Health Service was €20.9 million in 2001.

GENERAL COMMENTS

While there had been no major changes in this service in the past year, a number of initiatives were planned. The patients currently in St Teresa’s were to be transferred to the newly acquired premises, Solus Eile, at Parteen. This move had been the subject of ongoing industrial relations negotiation at the Labour Relations Commission. Discussions were progressing between the service, the Mental Health Association, and a voluntary housing agency in relation to providing accommodation for St Joseph’s patients at new premises on the Kilmallock Road. This new development, it was anticipated, would take another twenty-four patients from St Joseph’s Hospital. The suitability of transferring twelve, and therefore virtually all the remaining, intellectually disabled persons from St Joseph’s to the Lisnagry service was being pursued and the merits of this were not alone self-evidently obvious but the substantial improvement in every phase of their lives exhibited by those intellectually disabled who had already transferred was further evidence of the importance of placing these twelve in the same location. Finally, resources had been given to acquiring a nursing-home premises, currently on the market, which would accommodate a further twenty-three long-stay patients from St Joseph’s. If all of these initiatives were to succeed, then the number of patients remaining in St Joseph’s would be greatly reduced. This would then facilitate the transfer of the remaining patients, including those in Male 3, to the upgraded St Teresa’s Ward when its current occupants had been moved to Solus Eile.

As far as community services were concerned, there were plans to enlarge the current premises in all sectors. The first initiative in this regard was likely to take place at St Anne’s, Roxboro. The intention here was to provide a closer liaison with primary care, with outreach assessment and community-based crisis intervention as had been set out in the development plan for 2002. Further developments based on the accommodation needs of some patients currently in St Joseph’s, with particular regard to high-support residences or hostel wards for patients of greater dependency and a smaller number of medium dependency, were being pursued. Obviously, all of these moves forward depended on substantial capital funding.

Within St Joseph’s itself, accommodation ranged from the unsuitable, as in St Martin’s ward, to the quality care provided for the older female patients in Ward 6. As well as

being concerned about St Martin's the Inspectorate was unhappy about the accommodation provided in Male 3 and, to a greater degree, in Male 5. Also noted was the overcrowding and the general dilapidation of St Teresa's ward.

The entrance doors at the Department of Psychiatry, Limerick Regional Hospital, were usually locked. The protocols, procedures and practices in relation to locking these doors were examined in some detail. There did not appear to be a comprehensive policy statement in relation to this. We were struck by the ad hoc nature of this arrangement. Neither was there a procedure for reviewing the locking of the doors once this had happened, or for re-opening them. Other doors in the unit were locked and, although staff had keys to them, we were unhappy, as stated last year, with the security element of all of this, from a health and safety point of view. It also meant that the patients had only very limited access to the exterior from a small enclosed garden in the central courtyard. It was unclear how patients obtained access to the exterior, whom they asked, what the grounds for granting or refusing permission were, and so on. The corridor between the psychiatric unit and the rest of Limerick Regional Hospital was arranged around a ramp which was impassable by physically infirm patients, and so patients from the unit who required admission or transfer directly from the unit to the hospital had to be taken by ambulance, which was clearly wasteful and unnecessary. The layout of the unit itself was far from satisfactory, as noted on numerous occasions. It did seem a pity that when it was being refurbished and revamped not all that long ago, consideration was not given to some internal rearrangement leading to better observation facilities. The difficulties in providing observation within the unit might have had a bearing on the frequency with which the unit was locked.

The Inspectorate was disconcerted by the continuing admission of children aged under sixteen years to the unit (there were two present on the day of inspection) and the rule that all under-sixteens be specialled day and night. There were fifty beds for the catchment area, which should have been sufficient at all times. It was therefore disquieting to be told that there were sleeping out arrangements whereby, when there was a shortage of beds, patients were sent to St Joseph's until such time as a vacancy occurred back at the psychiatric unit, when they are transferred back there. In Unit 10, there was similarly a perceived shortage from time to time, with the result that patients were transferred from Unit 10 to other wards in St Joseph's. Paths to admission were through referral either from the day hospital by consultants, or from the accident and emergency department where, generally speaking, the decision to admit after 5.00 p.m. was made without consultant consultation. It appeared that this led to the possibility of inappropriate admission, without consideration of more suitable placement, unnecessarily filling beds in the unit and the requirement of sleeping out patients in St Joseph's. There was, however, a triage nurse on duty until 3.00 a.m. in the A & E department (there were three nurses in all staffing this post). It seemed too early yet to determine whether this initiative had had any impact. However, an appointment had been made of a full-time liaison consultant psychiatrist to the service, and in particular the Department of Psychiatry in Limerick Regional Hospital, and this might help also in stemming the flood of admissions. A further complicating factor was the practice of detoxifying alcohol-dependent patients as in-patients in the unit. The acute assessment provision for the later-life psychiatry service in the unit was inappropriate as these older patients did not have a defined sub-unit of their own, but instead shared

premises with younger patients. The Inspectorate has advocated that the existing but never-used accommodation for close observation should be used for this purpose. This was all the more relevant as it appeared the service was examining through its architect the possibility of providing an alternative close-observation sub-unit within the unit itself.

There was an urgent need for a skilled rehabilitation consultant within this service, particularly with the ongoing commitment to community resettlement of the long-stay residents of St Joseph's. However, there was only one occupational therapist currently in the entire service. This contrasted with the four/five psychologists and a similar number of social workers. There was a proposal to appoint a psychiatrist with a special interest in forensic psychiatry to the service, with sessional responsibility to Limerick prison and the courts. The creation of this post was currently under discussion. Seclusion was used in the locked female ward, but the frequency of this had greatly declined and there had only been six episodes in 2002 to date, involving two patients. All of these had been correctly documented, both medically and in the nursing notes, and signed for by junior doctors. Medical case notes designed by one of the consultants were of high quality, in their structure, their content and their layout, and should serve as an example to the rest of the country in this regard. Case note documentation was generally satisfactory and when temporary patients had had their temporary period extended, this had been satisfactorily annotated in the case notes.

It was noted that the evening meal and the evening medication was being given out at 4.30 p.m., which, in the Inspectorate's view, was far too early. It was felt that this was not to accommodate rosters, given that the shift worked was a twelve-hour one.

There were 103 temporary admissions to the Limerick mental health service in 2001 and seven patients had their temporary admission orders extended during the course of their in-patient stay. Twenty-four patients admitted voluntarily were regraded to temporary and two patients admitted involuntarily were regraded voluntary while hospitalised. One patient was admitted to the service on a PUM certificate. Ten patients, three male and seven female, admitted to the mental health service were aged sixteen years or under. Eleven patients took their own discharge from the service against medical advice in 2001. Appropriate procedures were in place to follow up those patients if deemed clinically appropriate. There were thirteen deaths in the service in 2001, all from natural causes. There were eleven recorded accidents to patients at St Joseph's Hospital and sixty-one recorded accidents to patients at the Department of Psychiatry, Limerick Regional Hospital, in 2001. Four of the patients' accidents at St Joseph's were deemed serious. There were sixteen recorded accidents to staff in the entire service and five were deemed serious. There were twenty-six recorded assaults on patients by other patients at St Joseph's and twenty recorded assaults on patients at the Department of Psychiatry. One of the patient assaults was deemed serious. Thirty-one of the assaults resulted in minor injury, scratches and bruising, twenty at the Department of Psychiatry and eleven at St Joseph's Hospital. The accident and incident risk management report was recorded in duplicate and was satisfactory.

Nine patients at St Joseph's and fifty-seven patients at the Department of Psychiatry were placed on one-patient-to-one-nurse special nursing supervision in 2001. There were 2,697

spans of special nursing supervision in the entire service in 2001. As special nursing supervision appeared to be used more frequently in this service than in other services visited, it was recommended that an audit be undertaken on the utilisation of and need for special nursing supervision. A review should also be undertaken of the duration of observation undertaken by one staff member on each span of special nursing supervision. Seven patients were placed in seclusion in the service in 2001 and there were forty-nine episodes of seclusion during the year.

Forty-seven patients were prescribed ECT treatment at the Department of Psychiatry, Limerick Regional Hospital, in 2001. The facilities for ECT were satisfactory, with appropriate waiting, treatment and recovery areas. There was a policy and procedure on ECT, which needed date of ratification and appropriate review date. A named consultant psychiatrist was responsible for ECT and there was an induction process for all new doctors. The nursing checklist, pre- and post-ECT, and the consent form in use within this service for ECT were all satisfactory. Fact sheets relating to this therapy were available for patient information and reference. A nurse was assigned to ECT and this nurse was trained in basic life support, attending the last refresher course within six months of this visit of inspection. The service was conducting an audit of the effectiveness of ECT, using the Montgomery and Asberg Depression Rating Scale. This rating was based on a clinical interview and clinical judgement was required to decide whether the rating lay on the defined Scale steps or between them. This audit had commenced in February 2002 and the Scale was used before and after each ECT treatment, and appropriately recorded. Results were due to be published in 2003.

Three patients took their own discharge from St Joseph's Hospital in 2001. There were forty-five recorded complaints made to the local complaints and appeals manager in 2001; all appeared to have been dealt with satisfactorily. While there was a complaints procedure, this should be available to patients at all levels of care. Patients must be aware of its existence and informed of how to use it. Patients should be encouraged to make a verbal or written complaint to the complaints person if they feel aggrieved or dissatisfied. Notices to this effect should be prominently displayed at every treatment location, with the name of the complaints officer. A handbook containing this information, as well as information on patients' rights, should be available for the information of patients and relatives. Written guidelines on the handling of complaints, alleging abuse/ill-treatment/neglect of patients in the mental health services should be available and known to all staff members and available on request to patients and their families. Notices communicating this information should be prominently displayed at in-patient centres.

A pin-point personal safety alarm was installed at the Department of Psychiatry, Limerick Regional Hospital, in order to ensure a speedy response was available for staff in emergencies. Not all staff appeared fully aware of their responsibility in relation to personal safety and the safety of patients and colleagues, as a number were not wearing the personal safety alarms at the time of this visit. A very haphazard system of recording the names of staff wearing personal safety alarms was in operation. Some staff had not signed the appropriate forms, some pin-point personal alarms were missing from the unit and it was assumed staff on duty had them in their possession. There was a need for a written policy and procedure on the use of the pin-point personal safety alarm, and one designated

person should ensure the system was in working order and staff complied with the local guidelines. There was a written generic safety statement, which was undated. This statement should be reviewed and updated, with a date of ratification and an appropriate review date. Site-specific safety statements should be available for staff information and reference in each local area. The Inspectorate was informed that a recent safety audit had been conducted, but staff were not aware of action taken to remedy any identified safety hazards. There was a policy for the locking of the external ward of the Department of Psychiatry. This door, it appeared, remained permanently locked. The system allowed for a daily review of the locking of the external doors but, from checking the documentation, this review took place infrequently. Patients interviewed during the visit of inspection in 2001 complained about the public address system at Unit 5B. During the current visit, this system was found to be quite intrusive. Written guidelines on the use of this system were required to ensure adequate privacy for patients.

There was a written policy for the ordering, prescribing, storing and administering of medicines, which was last reviewed in 2002. Generally speaking, the legibility of individual prescriptions within this service was of a satisfactory standard. Some prescription cards in some long-stay wards of St Joseph's Hospital required rewriting. On a small number of prescriptions examined in long-stay wards of St Joseph's, the number of discontinued prescriptions exceeded the number of current prescriptions. These should be rewritten as they posed an increased risk of drug administration error. Prescribed medication was appropriately recorded in the medical case notes. All policies and procedures were under review at the time of this inspection. It was suggested that grievance procedures and other staffing matters should be in a separate folder from policies, protocols and clinical guidelines relating to the care of patients. Emergency medical trolleys were located at strategic locations throughout the service. All were checked regularly to ensure medicinal products were within date and equipment was in working order. The policy and procedure relating to the management of patients' money and methods of informing patients of hospital charges appeared satisfactory. Not all areas in St Joseph's Hospital had designated smoking zones and this required attention. The notices informing patients of hospital charges required updating. The nurse care planning system consisted of the "Orem" model of nursing. Care plans were reviewed weekly, or more often if necessary. Nursing care plans should be audited to assess the standard of record and identify areas for improvement and staff development. There was a particular need to integrate the nursing assessment into everyday nursing practice. Nursing entries should record patients' wishes, preferences and suggestions about treatment approaches to ensure the active involvement of patients in making choices and decisions about their own care and treatment. Evaluation of nursing care plans should include patients' views about progress. The patient's primary nurse should be recorded in all nursing documentation.

A written policy was required relating to patients absent from the hospital without official leave. The hospital executive should ensure that the policy and procedure clearly indicated when the patient should be regarded as absent without official leave, who had responsibility to return the patient, who should take charge of the 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.

The policy and procedure should contain information on when to contact the Gardaí and when to contact the patient’s carers and relatives.

Three consumers were interviewed to assess their opinion of the psychiatric services provided. Two patients were on temporary forms, while the third was of voluntary status. Two had had multiple admissions, while for one it was a first admission. All had spent between five and ten weeks at the unit on their current admissions. All had a good opinion of the admission process and could name their primary nurse and consultant psychiatrist. They were all pleased with the regularity of their meetings with their consultant psychiatrists, but two felt there was too much reliance on the medical model and would have preferred greater inputs from psychological and counselling services. They were happy with their interaction with nursing staff, but one patient was very critical of night nursing staff and maintained that, once they had dispensed medication, they had their nursing job done and from then on were more interested in having coffee and watching television! All maintained they never received any booklet containing hospital and procedural information and one was quite critical at not receiving replies to written complaints. All agreed that ward activities and social events were moderately acceptable during weekdays, but all were of the view there were no activities available in the evenings and at weekends, and at these times they found life very boring. There was a mixed reaction to the amount of information supplied to them about their psychological problems and medications and their side effects, and all would appreciate receiving written information. None was aware of the existence of care plans and, if they were in existence, they were not involved in their production. There was general satisfaction with the levels of hygiene and décor and general ambience of the unit. None of the patients had a consultation with a social worker, while one had a consultation with a psychologist, which was considered very useful. As regards their suggestions as to how the services could be improved, one was too disinterested to make any suggestion, while the other two were anxious that activities be provided to allay boredom. They also wished to have more emphasis placed on psychotherapeutic interventions and greater access to outdoor pursuits. One patient was quite critical of the complaints procedure, whereby the Director of Services was the complaints officer. This patient suggested the complaints officer should be an independent person.

RECOMMENDATIONS

It is recommended that:—

1. Resettlement of the remaining residents of St Joseph’s Hospital proceeds along the lines, which have been thoughtfully planned and laid out by the service.
2. In conjunction with recommendation 1, a specialised rehabilitation team be put in place, leading to patient community resettlement and the closure of St Joseph’s, as well as for ongoing rehabilitation purposes.
3. The practice of transferring patients from Ward 5B to St Joseph’s and from Ward 10 to elsewhere within the hospital should cease.
4. The former, or projected, intensive care area in the psychiatric unit in Limerick Regional Hospital be adapted to provide an acute assessment unit for the later-life service.

CHAPTER FIVE

North-Eastern Health Board

CAVAN/MONAGHAN MENTAL HEALTH SERVICE — 2002 INSPECTION

INSPECTED ON 17 OCTOBER, 2002

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 103,000 was divided into two sectors as follows:

Sector	Population
Monaghan Community Mental Health Team	52,000
Cavan Community Mental Health Team	51,000

IN-PATIENT CARE

In-Patient care was provided at the twenty-bed acute psychiatric unit, Cavan General Hospital and St Davnet’s Hospital, Monaghan, which had seventy beds in two male and two female wards and one integrated ward. In addition, there are two specialised services, Psychiatry of Later Life and Community Rehabilitation Team, providing services to the Cavan/Monaghan catchment area.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	—	3	5	2	—	10	13.51
3 to 12 Months	—	—	—	1	2	—	3	4.06
1 to 5 Years	—	—	1	2	6	2	11	14.86
Over 5 Years	—	—	2	10	11	27	50	67.57
All Lengths of Stay	—	—	6	18	21	29	74	100
% of Total	—	—	8.1	24.3	28.4	39.2	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
7	41	1	9	10	5
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
—	1	—	—	—	74

Status of in-patients on the date of inspection 2002

Status	Male	Female	Total
Voluntary	36	30	66
Temporary	2	1	3
P.U.M.	1	—	1
Ward of Court	1	—	1
Total	40	31	71

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
204	1.9	70	34.3	77.45	22.55	199	6

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of Persons Attending in 2001
Day Hospitals	3	44	155
Day Centres	3	79	138
Out-patient clinics	8	653*	1,972

*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
12	53	—	—	5	60

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
17	26.5	201.5	58.5	23

COST

The cost of the Cavan/Monaghan Mental Health Service was €15.7 million in 2001.

GENERAL COMMENTS

The Cavan/Monaghan service pursued its delivery of services through the home-care programme for acute psychiatry and the assertive outreach approach for enduring mental illness with continuing success. There were two home-care teams, one for each county, based respectively in St Davnet’s Hospital, Monaghan and in the psychiatric unit of Cavan General Hospital. The assertive outreach team, currently covering both counties, was based in St Davnet’s. There was also a specialised service for older persons, with a day

hospital and outreach service, in St Davnet's and an acute assessment unit in Cavan General Hospital. The home care and assertive outreach programmes had been deemed remarkably successful, with a substantial decline in the need for acute in-patient beds. This service now had the lowest admission rate of any service in the country and the lowest acute bed usage profile.

The home-care team for Cavan occupied a corridor off the in-patient unit, with numerous offices, etc. During the summer, there were twelve patients here, which appeared to be the maximum during the year. One patient interviewed was quite articulate and insightful about conditions. He was admitted by his consultant and saw his consultant daily. He had a designated nurse whose identity he knew and found both the medical and nursing staff helpful. He was not fully informed about his treatment and was not a partner in its devising. He was not told the purpose of the drugs he was taking, had not been supplied with any literature about them, and was unaware of any side effects that they might have. He found the food monotonous and said it all tasted the same, even though there was a circulated menu that changed on a daily basis. He found the days long and boring, with little to do, although the staff did make some efforts to provide therapy on the ward. He would prefer to have had a single sleeping room as he found that other occupants of the room in which he slept snored. He claimed that the door to the unit was locked 'all the time', and he found this intimidating and restricting.

The new high-support community residence at the entrance to St Davnet's Hospital was now complete and awaiting commission. There was some delay in accessing the €150,000 necessary for its commissioning, however the residence should open early in 2003. This would result in twenty long-stay patients from Wards 1 and 5 of St Davnet's being transferred to it, with the subsequent closure of those two wards. A sector headquarters and day facility at Virginia was under construction and needed some additional funding for completion, but this was not expected to be a problem, other than in the short term. This was in association with a generic health and social care development that would also have a psychiatric component. The Virginia initiative would work in close association with the existing service at Baileboro, so that between them a full range of services would be available for this geographic area. A comprehensive development in Carrickmacross would provide a full range of services, including a sector headquarters, day hospital, etc. Further down the road, in about five or six years, a similar initiative was envisaged for Cavan town, probably in the grounds of Lisdarn hospital. The Monaghan area would be served by similar service components based at St Davnet's Hospital. Thus, there would be established in both counties a strategically placed full range of services. Some elements of care, although quantitatively of limited extent, were seen as requiring special approaches. Three such were enumerated, the first was the need for a consultant-led team to deal with the psychiatric aspects of intellectual disability, the second to cope with eating disorders and the third, on a regional basis, to cater for persons with serious behavioural disorders associated with psychotic disorder. The service was committed to a multi-disciplinary approach and was better served than most in terms of social work, occupational therapy and psychology, but recognised the necessity of strengthening these service components. The service participated actively in postgraduate medical training and there were two senior registrar posts currently established. There were four consultants and there was a

justifiable aspiration to have a fifth post for a specialised rehabilitation team. The service was well staffed with nurses, enabling it to carry out its home-care and assertive outreach programmes satisfactorily. These nursing teams worked in association with community nurses and served a role distinct and clearly identified from those working in the other teams. There was a nursing school based at St Davnet's.

There were eight patients in the psychiatric unit in Cavan General Hospital, one on leave at the time of inspection. All of these patients were from county Cavan and none of them were in the later-life psychiatry service. The door to the unit was locked most of the time, thereby restricting freedom and bringing a certain cachet to the unit of an undesirable nature. The Inspectorate was told that the reason for this was that the patients of the elderly service were often confused and rambling and needed containment. This argument was not entirely convincing, taking into account the relatively high staffing level of the unit. Furthermore, there were no written operational policies or procedures in relation to locking, reviewing, or unlocking the door. It was pointed out that, if the door was to be locked at certain times, there should be a clearly understood written policy and procedure in relation to this matter underlying the relevant decision-making process. The unit was small and did not have a sub-unit for older persons which, if it were in place, would obviate the necessity of locking the entire unit. It was pointed out to the Inspectorate, with some justification, that the number of older patients in the unit seldom if ever exceeded two and that it would be cost inefficient to create a sub-unit and more particularly, to staff it, for such small numbers. Most decision making in relation to admission of patients to the unit was community based by the consultant-led, home-care team. However, some patients did come independently to the A & E Department and less frequently, directly to the unit where assessment was carried out during daytime hours by a junior doctor in association with a member of the home-care team. Out of hours, however, the decision was made exclusively by a junior doctor who might or might not confer with the consultant on call.

Case note organisation in the unit was poor in terms of structure and order and needed revision (such an exercise had been carried out in St Davnet's). A patient interviewed in the unit was generally satisfied with the service received, although felt that patient participation in treatment decision making and planning was lacking, as was coherent explanation, either verbally or by means of written documentation, about the purpose of drug treatment and its side effects. The food, although varied and with a daily menu, was identified as bland and not particularly appetising. The day was often perceived as long and boring, with an inadequate provision of occupational and diversional activities. Staff had personal alarm systems, but did not wear them. They did wear identification badges. ECT for Monaghan patients, although infrequent, was carried out in the Cavan unit because no anaesthetists were available in Monaghan. One Monaghan out-patient was having ECT in the unit at the time of inspection.

The Cavan day hospital was situated in an adjoining corridor. Although it did treat acutely ill patients from time to time, including some visiting from the unit, it was functioning as a day centre rather than a day hospital. However, as indicated earlier, there were plans to

provide a comprehensive acute day hospital in the Cavan General Hospital complex in a number of years' time.

St Davnet's also maintained an admission unit, in which there were five patients on the date of inspection. This unit was quite heavily staffed by nurses, on an almost one-to-one basis both by day and, more surprisingly, by night. Because of the small number of patients here, there was a limited occupational and interactive programme operating. Staff did not wear identification badges or personal alarms. There were four other wards operating in St Davnet's, two catering for long-stay patients, one male and one female, and two for older patients, one male and one female. The female long-stay ward, with fifteen patients, had introduced a comprehensive clinical and social assessment scheme as a preliminary to moving patients to the new high-support residence at the entrance to St Davnet's. The male patients did not appear to have such a scheme in place yet, and some of them with behavioural social deficits did appear to need more intensive inputs before moving. Once the supervised residence referred to opened, these two wards were to close within the coming months. The residue of older patients, the majority of whom were over seventy-five years, would be absorbed into a generic service for older persons for the region.

Finally, the procedures relating to health and safety, complaints, drug storage and distribution, and risk assessment were satisfactory. However, the Inspectorate had made some suggestions in the 2001 Report in relation to some of these matters and it was gratifying to see that some of these had been taken on board. Others needed attention and this was pointed out to the relevant staff during the inspection.

During 2001 there had been two complaints to the local complaints manager and fourteen requests under the Freedom of Information Act. Seclusion was not practiced in either St Davnet's Hospital or the psychiatric unit, Cavan General Hospital, but special nursing did take place on a limited basis in the Cavan unit. One patient had been prescribed ECT during the past year. Patients were given an information booklet on admission. However, this booklet needed expansion, particularly in the area of the patient's right of appeal. This information should be communicated to patients and noted in case records. Similarly, the information should be prominently displayed in all admission and other areas.

RECOMMENDATIONS

Because the Inspectorate was generally in agreement with the careful and thoughtful planning that had gone into this service in relation to establishing community-based service components in the relevant geographic areas, recommendations were limited to urging rationalisation of admission facilities because of the cost-ineffectiveness of maintaining two units, one in each county and to the exploration of a mechanism designed to ensure that the acute admission unit in Cavan remained unlocked as far as possible.

LOUTH MENTAL HEALTH SERVICE — 2002 INSPECTION

INSPECTED ON 25 JUNE, 2002

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 110,064 was divided into three sectors as follows:

Sector	Population
Mid-Louth	30,507
North Louth	45,363
South Louth	34,194

IN-PATIENT CARE

In-Patient care was provided at St Brigid’s Hospital, Ardee, which had 105 beds in one male, one female and two integrated wards.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	—	12	7	3	—	22	23.40
3 to 12 Months	—	—	5	3	—	—	8	8.51
1 to 5 Years	—	—	3	8	3	14	28	29.79
Over 5 Years	—	—	—	13	11	12	36	38.30
All Lengths of Stay	—	—	20	31	17	26	94	100
% of Total	—	—	21.28	32.98	18.08	27.66	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
1	48	6	17	4	2
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
—	5	—	4	7	94

Status of in-patients on the date of inspection 2002

Status	Male	Female	Total
Voluntary	23	32	55
Temporary	10	7	17
P.U.M.	—	—	—
Ward of Court	5	2	7
Total	38	41	79

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
420	3.8	131	31	92.11	7.9	423	2

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of Persons Attending in 2001
Day Hospitals	—	—	—
Day Centres	2	77	96
Out-patient clinics	5	203*	855

*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
2	12	—	—	3	48

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
8	18	132.26	56	7.32

COST

The cost of the Louth Mental Health Service was €14.9 million in 2001.

GENERAL COMMENTS

The service providers in this region saw their catchment area as the sum of the two counties of Meath and Louth, with a combined population of close on 250,000 and growing. The Inspectorate felt that there were cogent reasons, set out in its reports of recent years, as to why these two services should be administratively and clinically separate. This might require some re-delineation of the current sectors, but even if this were not done, it would still be possible to align the existing sectors to the two counties individually. The account given at this point refers exclusively to the Louth service.

Since the Inspectorate visit to this service in 2001, some welcome initiatives had taken place. A number of intellectually disabled persons had been transferred to the specialised Drumcar service, and others to other community-based locations. In addition, a number of long-stay patients had been transferred to a new high-quality, high-support residence in Dundalk, called An Solasán. These initiatives had reduced in-patient numbers and had

allowed ward closures. As a consequence, there were now seventy-nine patients accommodated in four wards. Of these, St Dymphna's, which contained eleven patients, was due to close shortly, with the current residents there being distributed to community-based accommodation. Plans were afoot to extend and improve the sector headquarters, day hospital and day centre provision in Dundalk. Currently, all three were based in the Ladyswell Centre adjoining Louth County Hospital. This accommodation was cramped and did not meet adequately the needs of any of these three components. There was an ambition to provide similar sector-based facilities in the Ardee and Drogheda sectors.

An additional sector had been drawn up for Dundalk and an additional consultant appointed to lead that sector. An application had been made leading to the appointment of a later-life psychiatrist for county Louth. Efforts were being made to recruit occupational therapists (there was none currently) and social work personnel and to augment the existing psychology establishment. Recruitment of nurses to the service continued to be a problem and there were currently forty vacancies. Unfortunately, it was not possible to introduce a skill-mix staffing arrangement to substitute for responsibilities that did not require a nursing input. Finally, there was an express commitment to providing a specialised rehabilitation team for county Louth.

A project team had been established, chaired by the hospital administrator, to plan an acute psychiatric unit in Louth County Hospital, Dundalk, to replace the admission unit in St Brigid's. This was essential because the current admission unit was quite unsatisfactory and was currently continuously locked. The sleeping arrangements, arranged in the old Nightingale-style, were particularly unacceptable by the standards of modern psychiatric care delivery. There was an incidence of overcrowding and aggressive behaviour in the existing ward that emphasised the need for a speedy replacement of the existing admission premises. Because of the lack of community-based mental health centres, to which GPs should refer patients for assessment rather than directly to St Brigid's Hospital, there had been unnecessary admissions to the unit. The limited ability of the existing unit to contain difficult behaviour pointed out the urgency for the putting in place of the Santa Barbara intensive care unit for the mental health services of the NEHB. This resource consisted of the residence of the former RMS of St Brigid's and the planning of the project had been completed and submitted to the Department of Health and Children, but no progress had occurred on the matter in the past year. As matters stood, there was one patient on the admission ward who had, over the previous several months, been assaultive to patients and staff, and who would be more appropriately dealt with in an intensive care unit, and who, because of the lack of this, had been special-nursed continuously over a twenty-four-hour period at considerable expense, both financially and in terms of scarce nursing staff.

It was understood that there was a waiting list for consultation on new referrals at two out-patient locations, extending to as long as two or even three months. The Inspectorate was surprised to learn that the number of new patients seen at each clinic was restricted, in one instance at least, to one. It was felt not unreasonable to have two listed appointments for new patients at each clinic, given that the default rate was quite high, and having regard to the existing waiting list. It was not clear how urgent referrals were dealt with,

other than by referral directly to St Brigid's Hospital. Once again, the need for community- and sector-based mental health centres to take urgent referrals was evident in this situation.

The staff in St Brigid's Hospital wished to emulate the community out-reach programme of their fellow service in Cavan/Monaghan, but felt that, compared with this service, they were seriously under-resourced — to the extent that such an initiative was not currently possible. Nevertheless, the reduction of in-patient accommodation in St Brigid's should allow the deployment outwards of staff currently working in the hospital. In this regard, it was worth noting that many of the long-term residents in St Brigid's were elderly and that sourcing appropriate nursing home or equivalent accommodation for them would seem appropriate. Indeed, the Inspectorate's impression of the residents of the newly opened An Solasán high-support residence was that many of these were older persons and did not require high support and could, therefore, be moved to more appropriate accommodation, freeing up places for persons currently in St Brigid's.

The St Brigid's service had initiated a specialist nursing programme for patients with affective disorder and those who engaged in deliberate self-harm, involving two full-time nurse staff members. This service had been partially evaluated and, while the number of admissions of persons suffering from affective disorder had fallen only slightly, the length of stay in hospital of persons admitted from this programme had sharply reduced. As a result, it was hoped to provide a similar programme for those suffering from schizophrenia and associated illnesses, also based in Dundalk.

The county Louth service was recognised for its postgraduate medical training in psychiatry, both for specialist psychiatry and for general practice, and was now included in the senior registrar, or higher, training programme, with the first recruit to this post having taken up duty at the beginning of January 2002. There was also the Regional Nurse Training Education Programme, which was based in St Brigid's.

There were 420 admissions to St Brigid's Hospital in 2001, thirty-two of which were on temporary admission orders. Nineteen patients hospitalised on temporary admission orders had their involuntary admission orders extended during the year. Eleven of the involuntary temporary patients had their legal status regraded during their period of hospitalisation. Fourteen patients admitted as voluntary patients were regraded to involuntary during their hospital stay. One patient was lodged overnight at St Brigid's but was not formally admitted. There were 423 discharges and two deaths at the hospital in 2001. Twenty-three patients took their own discharge against medical advice during the year and appropriate procedures were in place for follow up if deemed clinically appropriate.

There were forty-five recorded accidents to patients at St Brigid's Hospital in 2001. Twenty-one of these resulted in mild injury and three were deemed serious. Of the seven recorded accidents to staff, five involved mild injury and one was deemed serious. There were thirteen recorded assaults on patients by other patients, none of which was deemed serious. Of the eight recorded assaults on staff, two resulted in minor injury and three

were deemed serious. The system in use at the hospital for recording, tracking and trending accidents and assaults appeared satisfactory. Guidelines issued some years previously on the reporting of certain matters to the Minister for Health under Section 272 of the Mental Treatment Act, 1945 should be available in the hospital policy manual for staff information and reference.

Twelve patients were placed on special nursing supervision at St Brigid's Hospital in 2001 and there were 258 spans of special nursing supervision, involving duty spans of twelve hours or more. As the use of special observation was significant, the Inspectorate suggested that its use be audited at regular intervals: reason for observation, length of time observed and any untoward incidents should be recorded. Records should also be kept of patients' own views on the process of special nursing observation. In addition, the nurses' views of the process of special nursing supervision should be recorded regularly and used to improve the implementation of the observation and supervision process.

While there was a written policy and procedure relating to seclusion, it was noted that seclusion was not used at St Brigid's and there was no safe room available for that purpose. The Inspectorate welcomed the new physical intervention restraint policy produced on 13 May 2002, with a review date in 2003. The Inspectorate welcomed on-going training for all staff in this service on the management and control of aggression and violence. The NEHB policy on physical restraint emphasised that all initial attempts to restrain aggressive behaviour should, as far as the situation allowed, be non-physical; and 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. When physical restraint was used in this service, 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 the medical officer. There was also provision for the completion and documentation of post-intervention care review and completion of accident and incident forms. The Inspectorate will review the implementation of this policy in 2003 with a view to having similar systems introduced elsewhere.

Noted on this inspection was the fact that most wards in St Brigid's Hospital were locked, however St Ita's Ward was an open ward. The service management should ensure that clear service-wide policies on the locking of external ward doors existed and that compliance was regularly audited. The frequency of locking of doors on non-secure wards should, in particular, be scrutinised to establish whether this indicated problems with day-to-day practice, or with inadequate staffing. It was recognised that the nurse in charge of any shift responsible for the care and protection of patients and staff and the maintenance of a safe and secure environment had discretion to lock the ward door if the behaviour of patients made this necessary. The principle of the least restrictive form of care should at all times be applied and it appeared that in some wards, particularly those housing voluntary patients, the doors were locked not because of any inherent management problems on the part of patients. This required review because most of these patients were not detained under the Mental Treatment Act, 1945. Locking of doors should never impede the free movement of patients whose clinical needs did not warrant such restrictions.

While there were no formal written complaints made by patients or patients' relatives to the local complaints manager in 2001, seventeen requests were made under the Freedom of Information Act and all appeared to have been dealt with satisfactorily. Management should attempt to monitor closely the handling and outcome of all verbal complaints, both to ensure minimum delay and to note any quality implications arising from the complaints. A written complaints policy and procedure was available for the information of staff in the ward areas, patients and relatives. Information on patients' rights under the Mental Treatment Act, 1945 was prominently displayed in ward areas. A comprehensive information leaflet containing information pertinent to a patient's stay in hospital was available for patients in the admission unit. All patients hospitalised at St Brigid's Hospital had regular access to a shop. Since the 2001 inspection there had been no research projects undertaken in St Brigid's Hospital governed by the Clinical Trials Act 1987-1990.

Twenty-four patients were prescribed ECT at St Brigid's Hospital in 2001 and the arrangements for ECT appeared satisfactory. A written policy and procedure for ECT was available and there was a named consultant psychiatrist responsible for the ECT clinic, with an appropriate induction process for all new doctors.

The written policy for the ordering, prescribing, storing and administering of medicines was under review. Written instructions on the use of prescription cards was required. The standard of prescription writing was variable. Not all prescriptions were signed and dated individually, and some signatures of the prescriber were illegible. There was an increased risk factor of drug error in a number of cards where discontinued prescriptions were greater in number than current prescriptions. The drug administration recording card should have provision for the nurse's signature in full when next this card is reprinted. The adequacy of the transport system for medicinal products between the pharmacy and the ward areas should be reviewed, as drugs were currently transported in unlocked, open boxes.

The Louth/Meath Tripartite Management Team met with their clinical colleagues in Louth and Meath on a bi-monthly basis, i.e. Meath one month, Louth the following month. There were regular monthly meetings between the Tripartite Management Team and the Assistant CEO for Regional Services. There was a safety committee at the hospital, incorporating the fire committee, which met quarterly, and appropriate minutes of meetings were kept. A recent safety audit had been conducted at St Brigid's Hospital and all safety statements were under review at the time of this inspection. In addition to the general safety statement, individual units had site-specific safety statements, which was very satisfactory.

The importance and value of policies, guidelines, procedures and similar documentation had been recognised within the service. Generally, staff appeared aware of the importance of approved policies, procedures and protocols in reducing the level of risk. At the time of this inspection, the Inspectorate was informed that all policies and procedures were under review. On the unit, a new policy manual was noted, containing several policies and procedures, some of which originated from the health board and others were specific to

the hospital. The content of those viewed was generally found to be detailed and unambiguous, often with responsibilities being clearly defined. However, there appeared to be no system that ensured that all documents were dated as per their implementation date, and no formal, consistent means of ratification and no compliance audit or assessment of effectiveness. The revised and updated policies and procedures should have a multi-disciplinary focus where appropriate, be individually numbered, and record the date of ratification and by whom ratified. Superseded policies should be removed from operation, with a pre-determined number of copies retained centrally for possible reference in the future. Policies should be formally introduced to all relevant staff, ensuring awareness and understanding of content. Staff should sign to say they have read, understood and intend to and are able to comply with the policy content.

It was noted that the policy review group should introduce guidance on the management of illicit drug use and drug-related incidents, setting out actions to be taken by staff members when there was a suspicion of illicit drug use or supply within the hospital, and a policy for staff to search and confiscate illicit drugs or dangerous weapons, with arrangements for the disposal of illicit drugs.

The patients' money management systems within the hospital appeared satisfactory. There was a system in place for informing patients of hospital charges and it was noted that information on hospital charges was appropriately recorded in the information leaflet for patients and visitors. The fire precautions within St Brigid's Hospital were all satisfactory. All equipment was checked regularly to ensure appliances were in working order and there was regular fire awareness training for staff. There was a smoking policy, with designated smoking areas, and all patients and staff appeared to comply with the policy. The designated smoking area in Unit 1 Admission Unit required cleaning and redecoration.

The nursing component of the clinical records comprised a dedicated booklet which was secured within the medical folder post-discharge. The nursing care plan comprised historical and personal data, assessment details and a plan and intervention section using the Roper model of nursing. The patient's primary nurse was entered in the nursing record and care plans were reviewed at two-weekly intervals or more often if deemed appropriate. The patient's name was appropriately recorded on each continuation page. All entries were accurately dated and were signed in full. Time of entry should also be recorded. Entries generally were written clearly and identified nursing problems that had arisen and nursing actions taken to rectify them. On one file examined, it was noted that there had been an alteration where an input had been made in a clinical file in error. Nevertheless, it was possible to read the original entry, as no Tippex had been used. While it was recognised that a simple error had been made and rectified, the date, time and reason for removal of the original entry from the file should be recorded and signed. While detailed nursing records were recorded on all patients, ideally the records 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 the patients' views in addition to the nurses' views about progress and any negotiated changes in the nursing care plan.

A number of patients in the acute admission unit of St Brigid’s Hospital were asked for their views on the level of care provided. Patients reported dissatisfaction with the immediate admission process. Two patients admitted on temporary certificates reported being frightened immediately on admission. All patients reported that they were met by nursing staff on arrival and introduced to the professional teams responsible for their care. Patients were not aware of the names of their primary nurses, but were aware of the names of their consultant psychiatrists and reported having reasonable access to them while hospitalised. Patients reported that they were not offered the information booklet or information leaflet about the hospital and its services, and all reported that they were not made aware of or given access to information about their rights under the Mental Treatment Act, 1945, or the local complaints procedures. Patients were satisfied that the service provided a variety of non-smoking areas, including quiet rooms and television lounges. All were satisfied with the sleeping arrangements and with the overall cleanliness of the ward and sanitary and bathroom facilities.

All were satisfied with the service provided by the medical staff, reporting that they were given reasonable information about the nature of their medical condition, including medication and treatment. Patients were not aware if a nurse had primary responsibility for their care and were not aware if there was a nursing care plan. All patients reported that they had adequate contact with nursing staff while hospitalised and that the nursing staff listened to their anxieties and queries about treatment or other problems, and tried to address them. None of the patients interviewed had seen a psychiatric social worker while hospitalised. One patient had seen a psychologist and was satisfied with the service provided. Patients expressed dissatisfaction with the level of interesting and beneficial activities provided during the day and at evenings and weekends. All reported that the days were long and boring and all complained about the locked door and their inability to gain access to fresh air, one patient stating, ‘Five minutes out each day would be wonderful’. This patient subsequently reported access to fresh air twice a week, accompanied by a nurse.

All patients reported that the service providers showed adequate respect for their privacy when giving them information about medical treatment or other advice.

RECOMMENDATIONS

It is recommended that:—

1. Sector headquarters, day hospitals and community mental health centres be put in place in the Drogheda and Ardee sectors.
2. Plans for the project team for the proposed psychiatric unit in Louth County Hospital be expeditiously drawn up.
3. The Santa Barbara project for intensive care be progressed.
4. An active rehabilitation team be put in place for the service.
5. Out-patient services be intensified with a view to abolishing the existing waiting lists.

MEATH MENTAL HEALTH SERVICE — 2002 INSPECTION

INSPECTED ON 9 AUGUST, 2002

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 90,010 was divided into three sectors as follows:

Sector	Population
Navan	28,519
Dunshaughlin	28,358
Kells/Trim	33,133

IN-PATIENT CARE

In-Patient care was provided at the acute psychiatric unit at Our Lady’s Hospital, Navan, which had twenty-six beds in one integrated unit.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	—	12	10	3	1	26	100
3 to 12 Months	—	—	—	—	—	—	—	—
1 to 5 Years	—	—	—	—	—	—	—	—
Over 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	—	12	10	3	1	26	100
% of Total	—	—	46.15	38.46	11.54	3.85	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	9	—	8	2	4
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
—	2	—	1	—	26

Status of In-Patients on the date of inspection 2002

Status	Male	Female	Total
Voluntary	7	10	17
Temporary	3	1	4
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	10	11	21

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
308	3.4	69	22.40	87	13	258	—

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of Persons Attending
Day Hospitals	—	—	—
Day Centres	3	56	83
Out-patient clinics	4	278*	809

*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	6	1	12

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
10	4	36.22	3	—

COST

The cost of the Meath Mental Health Service was €2.1 million in 2001.

GENERAL COMMENTS

The Inspectorate has often stated its belief that the Meath mental health service, with a population of well over 134,000 in the latest census figures, deserved to be administered as a separate service within the North Eastern Health Board. The Inspectorate believed that the senior nursing and medical administration in this service should be independent of the Louth service and pointed out that the appointment of a clinical director to the service would be a statutory requirement under new legislation. There were many reasons why the service would be best served by independent rather than subsidiary management from the point of view of clinical and administrative autonomy, practically as well as symbolically, and would also lead to more vigorous planning for the county Meath health services. It was understood that the tripartite management of the county Louth service which, de facto, acted as the senior management group for county Meath, did visit and held meetings in the Meath service with senior Meath personnel and that these meetings were minuted. It was hardly satisfactory that these should take place under the shadow of the county Louth management team. This may or may not have accounted for the slow

pace of development and the relative impoverishment of resources, both physical and human, in the county Meath service.

The nursing establishment for county Meath, at somewhat under fifty, contrasted with that of just under 200 in the Cavan/Monaghan mental health service, with a catchment area population of somewhat less than that of Meath. Additionally, there was no day hospital and only one high-support residence in the whole of county Meath. The Inspectorate felt that it was a matter of some urgency that these deficiencies be remedied.

It was understood that a new service of later-life psychiatry was to be created in county Meath. This was to be done by the appointment of a consultant in later-life psychiatry who would take up post towards the end of 2002 or the beginning of 2003. However, although human resources, in the shape of two nurses, a social worker and a psychologist, were to be appointed to the service, the lack of physical resources was worrying. There were no allocated acute assessment beds nor any dedicated continuing care beds for the service.

The psychiatric unit at Our Lady's Hospital in Navan continued to cater for the acute in-patient needs of the catchment area and, in addition, took a small number of patients from St Brigid's Hospital in Ardee when their acute beds were full; there was a reciprocal arrangement of lesser extent whereby a small number of patients (six in the first seven months of 2002) had been accommodated in St Brigid's because there had been no beds in the psychiatric unit in Navan. Even though this practice of patient interchange for acute purposes was of limited extent, it should be eliminated altogether. Seclusion was much in evidence in the unit in Navan during 2002. One patient was in seclusion during this visit of inspection and, towards the end of the visit, seclusion was ordered for another patient. Seclusion figures for 2002 were substantially greater than those of 2001; one patient had had a period of almost continuous seclusion during the month of January 2002 and there did not appear to have been seclusion orders in this case. The Inspectorate was concerned that junior doctors, for the most part, signed seclusion orders, and that the medical and nursing case notes relating to seclusion, the ordering of it, the perceived reasons for it, and its review, were not adequately documented.

In addition to considerable recourse to seclusion, it was noted that there were over 400 episodes of special nursing, i.e., on a one-to-one basis, in 2001 and that the figures for 2002, so far, were even higher. This was a costly process, both financially and in terms of nursing time. Fifteen-minute observations were carried out as well. This related both to seclusion and to patients deemed in need of this level of observation. The unit was kept constantly open during the day. While this was something the Inspectorate was happy to report, it might have contributed in some degree to the high rate of seclusion and special nursing. There was no adequate close-observation area within the unit and the seclusion room itself was not safe. The Inspectorate urged therefore that the County Meath service produce a design brief for the provision of such a facility within the unit to reduce seclusion and special nursing.

There was no OT department (and, indeed, no occupational therapist) in the entire service. This was reflected in the views of current in-patients interviewed in the course of this inspection, many of whom reported a high level of boredom during the day. Observationally, the Inspectorate was not impressed with the degree of patient — nurse interaction, even though there was a primary nurse scheme in operation — although this itself was partially devalued by the day-on day-off duty rota system.

Despite the inadequate community-based resources of this service and the lack of a directive in the admissions policy and procedures section of the policy and procedures document for the service, that all patients coming to the unit for assessment should be filtered through the A & E service and medically examined there before psychiatric assessment and, that following assessment, admission decisions were often made, without consultant consultation, the admission rate for the service remained low. The Inspectorate was reassured that the service did its best to provide a service with an in-patient base of twenty-six beds.

The two sector headquarters, one in Navan and one in Kells, were housed in buildings that were not really suitable for their purposes. This was realised by the service providers and there would soon be a replacement premises in Kells for the existing provision in Newmarket House, although this would continue to be operated by the service as, *inter alia*, a base for the outreach and domiciliary-based mental health service which it was hoped to put in place in Kells and the other two sectors of the service. Likewise, a new day centre was to be provided within a generic health structural provision on a site adjoining Our Lady's Hospital. This would replace the existing Tain Day Centre in the Infirmary building in Navan.

The Meath service acted as a training location both for psychiatric nurses from the school of the NEHB at Dundalk and for medical postgraduate psychiatric training as part of the Mater Hospital/University College Dublin psychiatric rotation. There were six NCHDs in place, one of them a general practice trainee, and two senior registrars.

The quality of documentary procedures in the service was of moderate degree. The structure of medical case records was generally acceptable, but the quality of medical documentation in relation to paths to admission, reasons why alternatives were deemed unsatisfactory, write-up of medical history and, in particular, the multi-disciplinary team intake assessment procedure and written care planning did leave something to be desired in many instances. Similarly, the absence of ICD numerical codes in the appropriate places in the record was a further omission. Prescription recording and signatures needed improvement and the issue of scripted versus block-written signatures and, where these were confined to initials, the necessity for having a key to signatures and initials opposite the staff member's clearly written name, was impressed on the staff.

There was no written evidence to suggest that patients were involved in their own treatment plans, or were aware of and participated in their own care programming. Neither was there evidence that they were aware of their rights under the mental health legislation. There was no written confirmation that they understood the existence of a complaints

procedure or knew who the complaints officer was and how complaints could be conveyed, should they wish to make them. There was a public information leaflet for newly admitted patients informing them about the service and its operation, and this was complemented by a booklet conveying and extending the same information. Likewise, there was a public information leaflet relating to the regional complaints procedure, but this seemed at some remove from the Meath unit itself, perhaps exemplifying the need for a more local approach to such and other matters.

In relation to more general quality issues, the furnishing and decoration of the psychiatric unit at Navan, and indeed of what few community facilities there were, were of a satisfactory order. The food provided both in the in-patient unit and in the day services was stated to be of good quality with, in the case of the unit at Navan hospital, a rotating menu available for patients' inspection. It was the Inspectorate view, however, that the beds supplied in the high-support residence, Rath na Riogh, were of an institutional, rather than domestic type.

Separate clinical arrangements were made for Clozaril administration and depot administrations. In the case of the former, this appeared to be on a catchment-area-wide basis and, while it was evident that patients from all over the county came to Navan to have their blood taken for laboratory estimations in association with Clozaril administration, it was felt that this would be better carried out at local level and by routine community nurse carers who could be responsible for taking the bloods and delivering them to the unit at Navan. This arrangement would also obviate the crossing of boundaries by two nurse teams, i.e., the Clozaril nurse on the one hand and the community nurse on the other.

A number of patients in the Department of Psychiatry at Navan General Hospital were interviewed on the date of the inspection to ascertain their opinion of the services provided. All were quite pleased with the attention and care they received from their consultant psychiatrists, nursing and other staff. They saw their consultant three times weekly and each patient said they could have appointments quite frequently with them if requested. They had a very high regard for the unit nurses and said their special key nurses were available at all times to talk to them. Their illnesses were fully explained to them, as were their medications, side effects, etc. They were involved with the nurses in the drawing up of their care plans. They found the ambience overall quite pleasing, but felt hygiene in the bathroom and toilet areas could be improved. They were always afforded maximum privacy and dignity. They were particularly pleased with the quality of meals provided. The only areas of complaint concerned the lack of a designated smoking area and the lack of organised activities. They found the mornings and weekends particularly boring. This was an area that local management should seek to rectify.

RECOMMENDATIONS

It is recommended that:—

1. The county Meath mental health service be administered autonomously and independently of that of county Louth.

2. The physical community-based resources, such as day hospitals and community residences, be greatly augmented in all three sectors.
3. The acute assessment and continuing care requirements of the forthcoming later-life psychiatry service be put in place as speedily as possible.
4. The design brief for a close-observation area in the psychiatric unit at Our Lady's Hospital, Navan, be drawn up so as to reduce the extent of seclusion and special nursing currently obtaining in the unit.

CHAPTER SIX

North-Western Health Board

DONEGAL MENTAL HEALTH SERVICE — 2002 INSPECTION

INSPECTED ON 9 MAY and 14 OCTOBER, 2002

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 121,412 was divided into four sectors as follows:

Sector	Population
Donegal Central	20,950
Donegal North Central	14,611
Donegal South Central	18,897
Donegal North East	26,945
Donegal North West	22,945
Donegal South West	17,064

IN-PATIENT CARE

In-patient care was provided at the acute psychiatric unit of Letterkenny General Hospital, which had fifty-two beds, and at St Conal’s Hospital, which had forty-two beds.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	2	17	15	6	2	42	48.8
3 to 12 Months	—	1	3	5	1	—	10	11.6
1 to 5 Years	—	—	3	8	2	—	13	15.1
Over 5 Years	—	—	2	15	4	—	21	24.4
All Lengths of Stay	—	3	25	43	13	2	86	100
% of Total	—	3.5	29.1	50.0	15.1	2.3	100	

in-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	37	—	18	10	5
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
3	6	1	6	—	86

Status of In-Patients on the date of inspection 2002

Status	Male	Female	Total
Voluntary	26	19	45
Temporary	15	10	25
P.U.M.	—	1	1
Ward of Court	—	—	—
Total	41	30	71

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
921	7.6	227	24.6	89.9	10.1	916	1

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of Persons Attending
Day Hospitals	1	20	117
Day Centres	7	185	304
Out-patient clinics	15	556*	1,430

*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
12	66	—	—	4	67

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
13.5	19	182.5	72.3	7.2

COST

The cost of the Donegal Mental Health Service was €15.36 million in 2001.

GENERAL COMMENTS

There were six sectors in the Donegal Mental Health Service and it appeared to the Inspectorate that the necessary physical resources to provide sector headquarters and day hospitals in all six sectors were still far from being available. One example of this deficiency was the manner in which the Letterkenny day hospital at Park House was currently functioning. Instead of being used exclusively for the Letterkenny sector, it served part of three sectors within a twenty mile radius of Letterkenny, and, in the Inspectorate’s view, dealt with a restricted patient clientele, while having the capacity, in terms

of space and size, to deal with the more actively disturbed patients of one sector. Having three sectors feed into this facility was unsatisfactory.

The Inspectorate commended the putting in place of a consultant-led service for later-life psychiatry, the provision of a dedicated consultant-led team for intellectual disability and the relatively recent putting in place of a child and adolescent psychiatry team for the county.

However, the main dilemma facing this service, and one of great concern to the Inspectorate, was the issue of providing an appropriate, modern, well-planned acute admission unit. In all recent reports the Inspectorate had criticised the existing admission unit because of its lack of space, the inappropriateness of its accommodation, and the consequent restrictions on patient care, whereby civil rights concerns arose in that patients were kept in bed, or in their pyjamas. A new acute psychiatric unit was therefore clearly and urgently needed. This could be provided either by upgrading the current unit or by building a new unit. The provision of the latter alternative could go ahead if the monies were available for it, which was currently not the case. However, the Inspectorate had serious reservations about the site identified as suitable, or as the only one available, for the replacement unit because of its distance from the general hospital and the impossibility of having any direct linking corridor between it and the hospital. However, the Letterkenny hospital management seemed determined to take over the existing unit to provide extra medical beds, a course which, if followed through, would mean that the psychiatric unit would have to move. The plan was to relocate the admission unit back into St Conal's Hospital. The Inspectorate had the gravest concerns about this proposal for innumerable reasons; principally because it was contrary to the national mental health policy of providing all acute psychiatric care in psychiatric units in general hospitals. The historical and traditional stigma of St Conal's lingers in the public perception of the former admission units, even though they might be physically upgraded. Furthermore, the existing arrangements to compensate for relocation, worked out with the representative nursing organisations, will have to be renegotiated if, in the fullness of time, the units are relocated back from St Conal's to a new psychiatric unit. It is conceivably possible that the existing admission unit could be extensively refurbished without vacating it in total, i.e. that the refurbishment could take place on a piece-meal basis. The existing complement of fifty-four beds was excessive for the catchment area and the Inspectorate felt that with some imagination and adequate use of community-based facilities, such as the Letterkenny day hospital, thirty beds should suffice for the acute in-patient needs on a short-term basis. This might allow for piece-meal refurbishment of the existing unit. It should be borne in mind that there is sufficient space around the existing unit to enlarge it and that, within it, the space currently used for office accommodation could be converted to patient care. It is highly likely that the current medical allocation of beds in Letterkenny General Hospital is being only partially used for acute purposes and that, in common with medical beds throughout the country, a substantial proportion of these beds are being used for sub-acute or 'step-down' purposes. With the vacation of St Conal's by psychiatry, there is no reason why the vacated three psychiatric wards could not be used for medical step-down purposes, thereby providing the extra medical beds perceived to be needed.

The catchment area population of St Conal's Hospital was 121,412. There were 921 admissions in 2001, which represented 7.9 per thousand of the population. 888 admissions were of voluntary status; the remaining ninety-three were of temporary status — fifty-two male and forty-one female. Fifteen patients who were admitted as detained patients were regraded to voluntary status. Five patients, three female and two male, transferred during 2001 to the Sligo Regional Secure Unit. A feature of the admissions during 2001 was the high number of diagnoses of alcohol-related disorders, at 312.

There was a written policy in the policy book for the ordinary prescribing, storing and administering of medicines. Those examined were satisfactory. Some patients were provided with written information on their medications. All patients should be in receipt of this. It was noted later, in the course of interviews with patients, that all patients wished this to happen. As regards guidelines for the administration of Clozaril, a special nurse was assigned to this area and patients and their families were provided with relevant information.

All patients were supposed to have a hospital brochure supplied to them, but three patients interviewed did not, in fact, receive one. The rights of patients under mental treatment legislation were printed and posted up in patient areas, but this now was not deemed sufficient and patients should have their rights explained individually to them. The same applied for complaint procedures. The complaints officer was a member of the general hospital staff. As to patient privacy, the staff made every effort to ensure adequate privacy to each patient, but the structural deficiencies of the unit militated against their best efforts and patients had complained about this. Ambulant patients had access to shop and canteen facilities on campus. The large number of patients confined to the dormitory areas made out lists of their requirements each morning, which were then supplied to them later on in the day. In interviews with patients, the main areas of concern were the inadequacies in bathroom and toilet facilities.

As regards administration issues, hospital management meetings were held on a fortnightly basis and the proceedings were minuted. One of these meetings was due to be held at 3.00 p.m. on the day of this inspection. At ward level, meetings attended by staff and patients were held on a monthly basis. As regards induction processes for nursing staff, these were organised by the Board on set days. Junior doctors also had a week-long induction course and were provided with a detailed manual. The RMS took responsibility for the induction process and for all matters concerning ECT. The timing of a safety audit varied from unit to unit and the process was currently ongoing. There was also a comprehensive policy and procedure for dealing with all aspects of patients absconding. The review of policy and procedures was an ongoing process; there was always some component of this under review. There was a multi-disciplinary committee from the entire general hospital campus engaged in risk assessment and risk management strategy. The psychiatric representative on this committee was the clinical director. Seclusion was not a feature of this service, instead, it relied on special nursing which was proving to be very costly. An area of great frustration to local management was their inability to relocate long-stay patients to two excellent group homes they had acquired and to nursing home beds already contracted for. All these excellent facilities were presently lying idle because

management had not reached agreement with nursing staff for their utilisation. It was patently wrong to have patients confined to inferior accommodation when excellent accommodation awaited them.

Initiatives and developments in this service since the last inspection included the purchase of two houses in Letterkenny town for use as high-support residences. Both of these were viewed from the outside and they appeared very well suited to their purpose. The one on the northern outskirts of the town, formerly a bed and breakfast facility, was a substantial detached house with an extensive garden giving it privacy and seclusion; the other was a house on the Ballybofey Road, less convenient to the centre of town, but equally suited to its purpose. It was estimated that both houses could take ten residents each from St Conal's Hospital. In addition, a minimum of eight older persons would be placed in nursing homes, another group of older patients would be placed in residential facilities run by the health board and the ten intellectually disabled patients in long-stay care in the service would have separate, alternative residential arrangements made for them. In this way, it would be possible to close the three wards in St Conal's. Of these three, one, St Kieran's was on the second floor and currently contained twenty-four patients. On the ground floor there were two units, St Agnes's which had sixteen patients, and St Bernadette's with nine patients. (The tenth intellectually disabled patient was long-stay in the acute unit).

An attempt had been made to provide for an additional six patients in high-support accommodation. However, because of difficulties with the nursing representative bodies, this initiative failed. It was not clear to the Inspectorate what alternative was now proposed for these patients, who were perceived to require more than the usual level of high support in their living accommodation. Some suggestion was made that this might be acquired within St Conal's Hospital itself.

Other initiatives during the year included the purchase of two adjoining premises in a housing development known as Solomon's Court, one of which was to serve as the headquarters of the later-life psychiatry service, headed up by the recently-appointed consultant in this sub-specialty. Additionally, a social housing development had taken place in Dungloe by voluntary effort, with a commitment to providing residential accommodation for psychiatric patients from the area. Finally, voluntary effort had produced a residential treatment centre for addiction within Co Donegal on the Derry/Donegal border.

Further initiatives, and one of them of substantial importance to the future of St Conal's Hospital, included the acquisition of a substantial warehouse premises in Letterkenny town to serve as a replacement day centre for that currently provided in St Conal's and, additionally, to substitute for the occupational therapy department currently in St Conal's. It was estimated that this day centre would provide seventy places in all. The Inspectorate was happy to hear that the drop-in centre in Letterkenny town, in the process of being set up during the 2001 inspection, was now open and operating very satisfactorily. The newly-opened high-support residence in Dungloe, which replaced a former, unsatisfactory building was now operating, though not yet at full occupancy.

Ninety-three patients took their own discharge from the acute unit at Letterkenny General Hospital against medical advice in the year 2001. Procedures were in place to follow up these patients if deemed clinically appropriate. There were eleven complaints or appeals made by patients or their relatives to the local complaints manager in 2001. In addition, there were six requests for information under the Freedom of Information Act. All matters appear 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 2001. Seclusion was not used in the service. Twenty-four patients were placed on special one-nurse-to-one-patient supervision in 2001 and there were 741 duty spans of special nursing supervision involving periods of ten hours or more. Twenty patients were prescribed ECT treatment in the Donegal service in 2001. There were forty-five recorded accidents to patients in the entire service in 2001; twenty-six resulted in no detectable injury; seventeen caused mild injury, such as scratches or bruising; two of the accidents were deemed serious. There were fourteen recorded assaults on patients by other patients; twelve resulted in no detectable injury and two resulted in mild injury, such as scratches or bruising. There were thirty-nine recorded assaults on staff, none of which were deemed serious.

Three patients were interviewed to assess their opinion of the psychiatric services provided. All were quite pleased with the admission procedures and were introduced to their care staff. All had primary nurses, but they gleaned this information from the notice board each morning. The nurses were all very helpful and patients were always treated with dignity and respect. They were very pleased with their consultant psychiatrists and with the frequency of their consultations with them; the junior doctors were also held in high regard. One patient requested the services of a social worker, which request was conveyed to the unit nurse. One patient, in pyjamas, appreciated that this was due to special observation procedures and totally agreed that this was a necessary precaution. No patient had received a booklet of general information about the hospital procedures and all would like to obtain one. Neither were they aware of a hospital complaints procedure or of patients' rights under the mental treatment legislation, although such information was posted on the walls in the patient areas. These matters should be contained in the hospital booklet and a staff member assigned to ensure that each patient received a copy. While all patients had had their medical problems explained to them, they all expressed a wish for written information in simple language about their medications. None of the patients had heard of a nursing care plan. There were some matters which all patients felt should be immediately remedied. These, in the main, were toilet and bathroom facilities. These areas left a lot to be desired — missing toilet seats, unsatisfactory shower rails, poor décor, etc. — and were heavily criticised. The patients were at pains to point out that the deficiencies were not the fault of the staff. One patient said the geriatric component of patients needs were too demanding on the nurses and did not allow them sufficient time for interacting with other patients.

RECOMMENDATIONS

It is recommended that:—

1. The acute unit at Letterkenny General Hospital be re-modelled and re-furbished pending a decision on its replacement.

- 2. Sector headquarters and day hospitals be provided in all existing sectors without these facilities.
- 3. The new supervised residential unit in Letterkenny be opened as soon as possible.
- 4. A separate alternative residential unit be provided for the ten Intellectually disabled patients remaining in St Conal’s Hospital.
- 5. Efforts be made to return long-stay Donegal patients, currently residing in the Special Care Unit in Sligo, to the Donegal service.
- 6. Psychiatric out-patients be moved from the acute unit to the out patient department at Letterkenny General Hospital.

SLIGO/LEITRIM MENTAL HEALTH SERVICE — 2002 INSPECTION

INSPECTED ON 1 MAY, 2002

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 89,648 was divided into four sectors as follows:

Sector	Population
Sligo City	27,933
West & South Sligo	22,292
North Sligo/North Leitrim/South Donegal	20,887
South Leitrim	16,836
West Cavan assimilated to Leitrim sectors	1,700

IN-PATIENT CARE

In-patient care was provided by the Mental Health Service at Ballytivnan, Sligo, which had fifty-six beds in one male, one female and one integrated ward.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	1	5	12	8	9	—	35	38.9
3 to 12 Months	1	8	18	10	5	—	42	46.7
1 to 5 Years	—	4	4	2	1	—	11	12.2
Over 5 Years	—	—	1	1	—	—	2	2.2
All Lengths of Stay	2	17	35	21	15	—	90	100
% of Total	2.2	18.9	38.9	23.3	16.7	—	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
2	23	1	12	6	4
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
8	6	1	2	25	90

Status of In-Patients on the date of inspection 2002

Status	Male	Female	Total
Voluntary	18	17	35
Temporary	8	6	14
P.U.M.	2	—	2
Ward of Court	—	—	—
Total	28	23	51

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
690	7.7	57	8.3	89.0	11.0	599	2

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of Persons Attending
Day Hospitals	1	30	116
Day Centres	5	87	129
Out-patient clinics	12	327	3,253

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
16	65	1	6	8	104

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
13	18	232	32.5	12

COST

The cost of the Sligo/Leitrim Mental Health Service was €14 million in 2001.

GENERAL COMMENTS

It was a great disappointment to the Inspectorate to find that construction work had not yet started on the new psychiatric unit at Sligo General Hospital. The design brief was agreed by the Department of Health and Children in consultation with the Inspectorate and local service providers approximately six years ago. Our disappointment was all the greater because last year we had been told that the psychiatric unit was in Phase II of the Sligo General Hospital development and that planning permission for the unit was about to be applied for. So far, planning permission had not been applied for. Having listened to accounts given to us by different persons, we were still unclear as to why progress on the unit had not occurred. We suspected that, at the core of things, there may have been attempts to alter the design as already agreed, mainly in the direction of enlarging the unit, particularly in adding accommodation on the first floor. This, we surmised, may have led to protracted and repetitive further discussions with the project architect and with the Hospital Planning Office in the Department of Health and Children. Changes in the agreed design resulted in considerable funding implications which had held matters up further.

We were anxious that each of the sectors in the Sligo/Leitrim service have a mental health centres/sector headquarters/day hospital structures in place. So far this had been only partially effective and much work needed to be done to ensure that the service delivered in the sectors was truly sector-based and outreach. As well as providing the necessary physical resources to bring this about, it would be necessary further to strengthen the associated professional staffing of psychology, OT and social workers. While the sectors lent themselves to the establishment of headquarters at Carrick-on-Shannon, Manorhamilton, Ballymote and Sligo town, and these centres represented the natural base of sector development, some revision of the existing sectors would seem necessary. Having carefully considered sector layout and composition, some revision would seem appropriate to improve the logical disposition of the sectors.

The Inspectorate reported in 2001 that a newly-provided, decorated and furnished house in an acre of ground in Manorhamilton and with obvious potential as an excellent supervised residential unit, had not come into operation. It was our understanding last year that patients were to transfer from the adjoining Bank House in Manorhamilton and from the Ballytivnan Mental Health Centre within a matter of weeks. As far as we could understand the reason for the delay, it had something to do with water seepage on the site, but this seemed to be a very tentative explanation and no one seemed quite sure as to what the real reasons were, in structural terms. In the meantime, there was an apprehension that, because of the delay, the house might be requisitioned for other non-psychiatric purposes.

Extensive renovation had been carried out at Summerhill Lodge at St Patrick's Hospital, Carrick on Shannon, and the decoration and furnishings had been greatly improved. However, it was not clear that the water penetration on the upper storey, which led to the refurbishment, had been entirely eliminated. We welcome the redecoration and general

upgrading of the supervised residential unit at Cashelgarron. The nearby Castlecourt supervised residential unit required similar treatment to bring it up to the desired standard. It was noted that the residents in Castlecourt had insufficient occupation or activity during the day. The Inspectorate would urge that some activity be provided for these patients, either in the free-standing garage-type building in Castlecourt which was currently lying idle, or by transporting them to Cashelgarron where activities took place daily.

There were approximately fifty patients, including admission patients, in the Ballytivnan Mental Health Centre. These patients were distributed between the male and female admission wards and the regional special care unit, which had ten patients on the day of inspection. When the acute unit was constructed and functioning, the two admission wards would, of course, close. There was no substantive plan currently in place to deal with the occupants of the special care unit. The Inspectorate would suggest that a suitably staffed and supervised residential unit of a limited number of places, be provided in each catchment area, Sligo/Leitrim and Donegal, as alternative accommodation for the long-stay patients in the current unit, thus allowing it to close. During inspection of the admission units, the Inspectorate was struck by the lack of occupational arrangements for patients, many of whom, on interview, emphasised that their days were long and boring and unenlivened by any form of occupational activity. A very limited activity programme, catering for only six at a time of the approximately forty admission patients, operated on four days a week, being closed every Wednesday. Also notable was the high level of staffing in the long-stay ward in the Ballytivnan Centre, which was on a one-to-one basis during daytime hours.

The Inspectorate was struck by the special nursing arrangements existing in the admission units, whereby any patient deemed to require special observation was the subject of automatic special nursing by two nurses. This, apparently, was the consequence of some arrangement with the representative nursing bodies, which was the subject of ongoing discussion. The generous nurse-staffing levels of the supervised units were also noted. Overall, the Inspectorate noted the very ample nurse complement of the service, with over 200 nurses for a population of approximately 90,000. Quite clearly, there was ample opportunity to deploy nurses to an outreach, sector-based, community-oriented service; the Inspectorate was informed that the service was thinking along these lines.

Given the ample human resources available to this service, the Inspectorate felt that it was now time to plan a strategic, time-framed blueprint for the service, based on the principles of sector and community orientation and with a strong outreach component. While management meetings took place on a monthly basis, the Inspectorate felt that the representation of the management group needed to be widened to reflect a multi-disciplinary orientation and to involve senior administrative personnel.

The Inspectorate welcomed the setting up of a specialised later-life psychiatry service, with the appointment of a consultant and the commitment of nursing staff to it. Less satisfactory was the fact that no physical underpinning existed for this service at the time of inspection. The service had no physical headquarters, no assessment beds, and no plans appeared to be in place to provide it with a day hospital. Also welcomed was the imminent

appointment of a consultant and team for the intellectual disability service. It was also reported that there were plans to press ahead with the setting up of the rehabilitation team. It was noted that liaison psychiatry services to Sligo General Hospital were provided by the consultant on call. With the moving of the acute psychiatric component of the service to the general hospital, the Inspectorate felt that a dedicated consultant, working on a part-time basis, with a back-up liaison nursing service should replace the existing arrangement.

The day centre at Manorhamilton, while serving a useful purpose, was inadequate and should be replaced. There was a need to integrate this facility into the general health services already provided there. Similarly, the out-patient facilities at Ballymote day centre should be integrated into new facilities at the health centre.

There were twenty-six recorded accidents to patients and thirty-eight recorded assaults on patients by other patients in the Sligo Mental Health Service in 2001. One of the patient accidents was deemed serious. Five of the accidents and nine of the assaults resulted in minor scratches and bruising. None of the assaults were deemed serious. The administrative system for the recording of accidents and incidents in this service was satisfactory.

There were 710 episodes (duty spans of ten hours or more) of special nursing supervision in 2001, involving thirty-one patients. Two staff were assigned to each patient receiving nursing supervision, regardless of whether two staff were necessary or not. Some of these episodes related to the care of patients at Sligo General Hospital. There was a need for a written policy and procedure relating to special nursing. All special nursing in this service should be audited, with a view to determining the reasons for its use, its duration, and patient and staff reviews of the process.

Nine patients were placed in seclusion in the Sligo service in 2001 in a total of forty-six seclusion episodes. Between 1 January 2002 and the date of inspection, there had been twenty-six episodes of seclusion, involving seven patients. The seclusion facilities had been upgraded substantially in recent years and appeared structurally appropriate. There were no blind spots in the seclusion room. Access to the room was through the long ward corridor. However, there was reasonable privacy for patients, given the limitations of the design of the building. Fifteen-minute nursing observations were recorded and kept in the medical file. There was a written policy and procedure on the use of seclusion. A seclusion register was maintained. However, some of the signatures in the register were illegible and records of at least three seclusion episodes were unsigned. All of this required attention.

There were five recorded complaints made to the local complaints manager in 2001. All complaints appeared to have been dealt with satisfactorily. There was a need for a written complaints policy and procedure document, which should be available in each clinical area for the information of patients and staff. Information given to patients about the complaints procedure should be recorded in the patients' clinical notes.

There were forty-five temporary admissions in this service in 2001; no patients had their temporary admission orders extended during the year. Fifty-six patients took their own

discharge from in-patient care during the year and the necessary procedures for follow up, if deemed clinically appropriate, were in place.

Seven patients were prescribed ECT treatment in 2001. Because of the lack of adequate facilities at the Ballytivnan unit, ECT treatment was administered to patients in the theatre department of Sligo General Hospital. There was a written policy and procedure on the administration of ECT, with a named consultant psychiatrist responsible for the ECT clinic. An appropriate induction programme on ECT was in place for new doctors. There was a pre- and post-ECT nursing check list in respect of each patient. Some of these were completed satisfactorily; some were undated; and some were not signed by the ward nurse or the ECT nurse. This required attention. All post-ECT nursing observations were recorded and signed. Two separate consent forms were in use: one for voluntary patients, which was a specific form for modified ECT and one for non-voluntary patients, which was a form used for 'consent for operation to non-voluntary patient by relatives'. The consent form should be reviewed and updated. One form should be in use specifically for ECT treatments. This form should be divided into three sections, one part for consent by the patient, with provision for the patient's signature in full and the date, the second part for consent by the relatives, stating relationship to patient, with provision for the relative's signature in full and the date, and the third part for the doctor's confirmation that the procedure was fully explained to the patient or the patient's relative where appropriate, with provision for the recording of the doctor's signature and the date.

There were general health and safety statements available in the clinical area, but they were not site-specific and were unsigned and undated. All of this required review. There was an emergency box with appropriate resuscitation medication and equipment at each location. This box was checked weekly by the clinical nurse manager in the female admission unit. There was a need for regular checks of the emergency equipment in the male unit and the recording of such checks. There was a panic-alarm system in operation. While it was reported that most staff wore the personal alarms supplied, it was noted at the time of inspection that not all staff carried such alarms. There was a need for a written policy and procedure on the use of the panic alarms.

This service had a comprehensive documentation policy on patients absent without official leave, indicating when the patient went AWOL, who had responsibility for returning the patient, who took charge of the procedure, and other pertinent information relating to notifying patients' relatives and the Gardai and searching the grounds. All of this was satisfactory. The management team of this service met on a monthly basis and minutes of meetings were kept.

There was a policy and procedures manual with an index of all policies and procedures. Additional policies or guidelines relating to patients' voting rights, searching a patient's belongings, locking external ward doors, risk assessment and management, and the management of illicit drug use or drug-related incidents, should be added to a revised, updated policy manual.

There was a written policy and procedure, last reviewed on 18 October 2000, for the ordering, prescribing, storing and administration of medical preparations. The next review of this policy and procedure was scheduled for October 2001, but there was no record of this having taken place. An examination of individual prescriptions indicated a low risk of drug error as most were either in block writing or, if scripted, were not difficult to read. Similarly, while most entries in the discontinuation column were signed and dated individually, a small number contained no signature and some signatures were illegible. The drug administration recording card should have provision for the nurse's signature in full. The provision for recording drug allergy so that the information is rapidly available to staff was satisfactory.

An inspection of case note documentation indicated a generally satisfactory level of clinical documentation. Patients' names were clearly recorded on each continuation page and each newly admitted patient had a full medical evaluation, including comprehensive admission notes, mental state examination, physical examination and a clear immediate management plan, all appropriately documented. There was a need for written instructions on filing of documentation within the medical record and the storage of loose clinical material within the file required review. Risks associated with loose clinical material included delay in accessing pertinent information and lost or misfiled clinical information. All entries in clinical notes should be signed in full and include the date and time of entry clearly marked.

There was a hospital brochure with pertinent information for patients relating to their stay in hospital. Information on patients' rights was prominently displayed in the clinical areas. Patients had access to a shop in the hospital complex and had reasonable access to fresh air. The upgrading and redecoration of the units at the Ballytinvnan complex was welcomed. The toilet and bathroom areas were of a very good standard. All patients had reasonable privacy in the sleeping areas, with bed curtains and individual lockers.

Nursing documentation in this service related to the Roper model of nursing. Appropriate nurse-care planning was in place, but there was a need for greater correlation between the nursing assessment, nursing intervention and nursing notes. While all entries in the nursing notes were accurately dated, the time of entry should also be recorded. All entries should be signed in full, with block lettering alongside the signature of the first entry. The patient's name was appropriately recorded on each continuation page of the nursing record. All nursing documentation was under review at the time of this inspection. New records should reflect the involvement of patients in planning and making choices and decisions about their own care and treatment. Similarly, evaluation of nursing care plans should include patients' views about progress.

A number of patients were interviewed to ascertain their views on the level of service provided. Patients were generally satisfied with the admission process and with the courtesy and helpfulness of staff. All reported that they had been introduced to a named nurse on admission and that they were informed of the name of the consultant psychiatrist with responsibility for their care. All patients reported that they were shown around the ward on admission, or within a reasonable time thereafter, by nursing staff. Two patients had

not been allowed wear their own clothes post admission. One patient thought this was hospital policy relating to this illness; the other reported that no explanation was given. Two patients were offered an information booklet about the hospital and its services. One had no knowledge of any information booklet. None of the patients were made aware of their rights under the Mental Treatment Act, 1945 or informed of the local hospital complaints procedure, although one patient was aware that information on patient rights was posted on the wall.

When asked whether the service provided interesting and beneficial activities during the day and on evenings and weekends, all patients expressed dissatisfaction. Patients stated that the only diversional activity available was television viewing or use of the smoking room. On the day of inspection the occupational therapy unit was closed because staff were on study leave. This, it was reported, was a regular weekly occurrence. Patients were generally satisfied that the service provided a variety of non-smoking areas, including quiet rooms and television lounges. Patients were generally satisfied in matters of privacy and dignity relating to their care and with the sleeping and sanitary arrangements. Patients were generally satisfied with the heating and overall cleanliness of day rooms and bathroom facilities. Similarly, they were satisfied with the quality and quantity of food provided and the seating arrangements in the dining rooms. The facilities for visitors were described by all patients as satisfactory. When asked whether they had been informed about the range of activities and social opportunities within the service, patients replied that there were 'no activities' and 'nothing offered'. One patient was very satisfied with the care he received from his consultant and from junior medical staff. Another patient was very satisfied with the consultant, but suggested that the junior medical staff spend more time talking to patients. Another patient reported greater satisfaction with the junior medical staff as compared to the consultant. One patient reported having been given reasonable information about the nature of his medical condition, medication and treatment. Another patient reported receiving adequate information on his medical condition but not on his treatment. A third patient was not satisfied with the information given in relation to his medical condition or treatment. All patients reported that their consultant psychiatrists discussed their prescribed medication with them. All reported that they had either no or little involvement in decisions affecting their care, such as planning care with the doctor or nurse. Patients reported adequate contact with nursing staff. Patients were not aware if they had a nursing care plan, or if nurses were assigned individual responsibility for their care and treatment. Two patients reported access to a social worker while hospitalised. None of the patients had seen a psychologist during two weeks of hospitalisation. When asked what could be done to improve service provision, one patient replied, 'lots of activities' as he was 'bored to death'. The same patient also requested private consultations with the medical team, rather than meeting the multi-disciplinary team as a group. One patient requested that his psychiatrist see him every day and asked for improved shop opening hours at weekends. The third patient requested that activities to eliminate boredom be introduced, that nurses give more time to patients individually to discuss their problems, that patients have more personal time with the medical staff, and that fuller explanations in relation to medication and its side effects be given.

RECOMMENDATIONS

It is recommended that:—

1. Construction of the acute psychiatric unit at Sligo General Hospital proceed as soon as possible.
2. The day premises at Carrick-on-Shannon be upgraded or replaced.
3. A range of occupational, recreational and diversional activities be introduced for all patients at Ballytivnan in response to their expressed wish for such services.
4. Nursing care plans be audited to assess standards of record and identify areas of improvement and staff development.
5. A written policy on the use of the personal panic alarm be introduced.
6. A revised ECT consent form be introduced.
7. Information on patients' rights under the Mental Treatment Act, 1945 be brought to their attention, and records kept on the clinical files of rights information given.

CHAPTER SEVEN

South-Eastern Health Board

CARLOW MENTAL HEALTH SERVICE — 2002 INSPECTION

INSPECTED ON 31 JULY, 2002

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 41,597 was divided into two sectors as follows:

Sector	Population
Carlow North	20,597
Carlow South	21,000

IN-PATIENT CARE

In-patient care was provided at St Dympna’s Hospital, which had 115 beds in two male, one female and two integrated units.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	1	4	9	2	2	18	19.57
3 to 12 Months	—	—	2	3	1	1	7	7.61
1 to 5 Years	—	—	1	4	4	3	12	13.04
Over 5 Years	—	—	10	20	15	10	55	59.78
All Lengths of Stay	—	1	17	36	22	16	92	100
% of Total	—	1.09	18.48	39.13	23.91	17.39	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
3	15	1	3	1	1
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
2	7	—	26	33	92

Status of In-Patients on the date of inspection 2002

Status	Male	Female	Total
Voluntary	75	20	95
Temporary	3	3	6
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	78	23	101

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
296	7.0	62	20.9	94	6	291	8

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of Persons Attending
Day Hospitals	2	40	239
Day Centres	4	77	66
Out-patient clinics	5	211*	1,370

*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
4	23	4	40	—	—

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
5.5	10.5	126	40	4.7

COST

The cost of the Carlow Mental Health Service was €13.43 million in 2001.

GENERAL COMMENTS

The Carlow Mental Health Service was divided into two sectors, one North and one South. Each sector was serviced by a consultant-led team, an assistant director of nursing, a community mental health nurse, additional nursing staff, including one in each sector responsible for outreach and crisis services, a psychologist, an addiction counsellor and both sectors shared a social worker and occupational therapist.

Community-based facilities comprised a day hospital serving both sectors and based in St Dymphna's Hospital. In effect, though, this was not an acute day hospital but, rather, an amalgam of a day centre and drop-in social centre. Additionally, there were day centres in Tullow and Hacketstown in the North sector and in Carlow town and Leighlinbridge in the South sector, although some of these operated only on a part-time basis. There was said to be a partial outreach programme in both sectors, conducted mainly by community nursing staff. Community residences were all located in Carlow town, served both sectors and ranged from a twenty-four-hour supervision operation to unsupervised group home status. There was also a ten-bed residential rehabilitation unit called Clann Nua, located in St Dymphna's Hospital, whose residents had been discharged from in-patient care.

The current Carlow service was joined with that of Kilkenny to provide a joint Carlow/Kilkenny sector service. The nuclear element in this conjunction was the opening of the acute psychiatric unit at St Luke's Hospital, Kilkenny, and the closing of the current admission facilities in St Dymphna's Hospital. This was scheduled to take place in February 2002 and, because of this, the threatened occupation of the unit by the temporary transfer of medical wards from St Luke's to enable refurbishment to take place in these medical wards, was revoked. It was therefore particularly disappointing to the Inspectorate to learn that the opening of the psychiatric unit for mental health purposes had now been deferred to November 2002, allegedly due to the non-resolution of some residual industrial relations difficulties and the need to resolve some minor structural snags. The Inspectorate was told, both in 2001 and during this visit, that considerable work had been put into integration of both services and that, as part of this endeavour, an internal competition was shortly to be held for a clinical director for the joint services. In the meantime, Carlow and Kilkenny maintained separate services.

The mental health component of St Dymphna's Hospital had contracted considerably over the years and now contained four wards for psychiatric purposes. The remainder of the hospital provided a variety of clinics and services for general health purposes, such as ear, nose and throat, and ophthalmic consultations. An obstetric clinic functioned on St Dymphna's campus, the Catholic Church had become a military museum, and there was an extensive community-care operation based in a freestanding premises also on the campus. Off the Athy Road from the hospital, a large house in its own grounds, Kelvin Grove, catered for twenty-one intellectually disabled persons and, in fact, constituted the fifth ward of St Dymphna's.

Including Kelvin Grove, there were ninety-seven patients in the hospital at the time of inspection. Of these, approximately a dozen were long-stay county Kildare patients from the days when St Dymphna's catered for the two counties of Carlow and Kildare. Forty-one per cent of the residents were aged over sixty-five years. The main components of the St Dymphna's patient population consisted of three groups, the intellectually disabled, older persons, and approximately twenty patients in the acute admission wards. There were, in addition, a small number of younger long-stay patients requiring rehabilitation. It seemed logical to the Inspectorate that when the acute component moved to St Luke's Hospital, Kilkenny, the remainder of St Dymphna's residents should be de-designated. The intellectually disabled would then move from Kelvin Grove to a specialised service provided for

them in new residential premises comprising three bungalows on the St Dymphna's campus. Care of the older persons, being de-designated, should form part of a comprehensive service for this age group operated in conjunction with the adjoining Sacred Heart Home, and with the input of the newly created later-life psychiatry service in the Carlow/Kilkenny catchment area. The younger, long-stay St Dymphna's residents, relatively few in number, could then become the responsibility of a specialised rehabilitation service for the new catchment area, replacing, as far as county Carlow was concerned, the Clann Nua residence and the soon-to-be-opened Greenbanks rehabilitation residence in Carlow.

The sooner all of this came about, the better, as conditions in some components of the current St Dymphna's caused grounds for concern. The admission unit was quite unsuitable for its purpose and the observation facilities from the unsuitable nurses' station were inadequate, partially explaining the heavy reliance on seclusion in the unit, which was, admittedly and appropriately, unlocked. The Kelvin Grove house was in a dilapidated condition, both externally and, despite recent repainting internally, was unfit for its purpose. The Inspectorate appreciated the expectation was that Kelvin Grove would soon close and its current residents be transferred to three bungalow units on the St Dymphna's campus. However, there was no date, it appeared, as to when construction of these units was to begin. It was a continuing worry that, in the meantime, Kelvin Grove would continue to operate.

It was unsatisfactory that the day operation was embedded in the centre of St Dymphna's. It was clear to the Inspectorate that this unit was not an acute day hospital and functioned merely as a day centre or drop-in centre. Every effort should be made, and there was, it was understood, a commitment to this, to obtain an appropriate mental health centre, including a day hospital operation in the town of Carlow, away from St Dymphna's. Likewise, the addiction service, with its counsellors based in St Dymphna's, would seem to the Inspectorate to be too closely associated with in-patient psychiatric services and insufficiently in contact with the open community, including primary care. The same stricture would apply to the family therapy operation and the location of social work services within St Dymphna's. The two centres of occupational activities provided in St Dymphna's, at the Dove and Dolmen centres, were impressive but, here again, and looking to the future, a community-based location for them would seem more appropriate. The social skills and training centre in the grounds of the hospital was reasonably appropriately located and, particularly because of the horticultural operation, the Inspectorate would see no difficulty in this continuing in its current location.

The Inspectorate was concerned at the extensive use of seclusion in St Dymphna's and the deficiencies surrounding the implementation of protocols relating to it. One patient in Kelvin Grove spent long periods of every day in seclusion following a serious suicide attempt some months previously. These episodes of seclusion were inadequately documented and invariably signed for by a junior doctor. The Inspectorate was also unhappy at the continuous seclusion of a newly admitted patient in the admission unit for a period of five days. As far as could be determined from the inadequate medical and nursing documentation, this person had been secluded on the prescription of a junior doctor and

there was no evidence of a continuous review process during that five days. It was incontrovertible, in the Inspectorate's opinion, that more critical review should be given to the use of seclusion and to clinical documentation concerning this process when it occurred.

Further inadequacies in clinical documentation concerned the extension of temporary patient reception orders or of re-certification. Invariably, there was no mention in medical clinical case notes of the fact that extension had occurred, let alone the justification for such extension. In fact, in most instances, it was impossible from case note material to determine the legal status of patients. Other shortcomings in the patients' legal documentation were noted and pointed out to staff.

Many patients were referred, or referred themselves, directly to St Dymphna's with a view to admission. Quite often, it seemed from case note documentation, patients were evaluated and a decision made to admit them by relatively inexperienced junior doctors, without recourse to consultant advice. Case note structure and composition was reasonable, but there were obvious deficiencies, some relating to legal status, as mentioned, and others such as the absence of ICD diagnoses. It was not evident from case note material that a multi-disciplinary assessment and a care programme approach had been adopted and outlined on or shortly after admission. On some occasions, it appeared that patients had not been seen by a consultant within a reasonable time of admission. There was no documentary evidence to indicate that patients had been involved in their own care planning, or in other aspects of their care. Although the Inspectorate was told that a primary nurse care system operated in the admission unit, this was not confirmed by those patients interviewed.

A common feature of patient complaint was the lack of occupation. For most patients in the admission ward, little was provided in the way of occupational or other vocational or life-skill activity relevant to their illness. Some nurses wore identification badges, making it easier for patients to relate to them, but most did not. An informative booklet about St Dymphna's Hospital and its service was available and was, it was claimed, given to all new patients on admission. The complaints procedure was documented in the policies and procedures book, but was not mentioned in the information handbook for patients and relatives. In practice, none of the patients interviewed knew whom they should complain to if they had problems with the service and the identity of the complaints officer was not known to them. Despite the fact that there was a paragraph in the patient handbook headed 'What are my rights?' no specific information was given as to whom patients had the right to contact outside the health board. While there was a notice displaying this information, patients interviewed were unaware of it and said it had not been specifically drawn to their attention.

Despite their being a practice guidelines publication for nurses in the SEHB covering, among other matters, the use of abbreviations, there did not appear to be an analogous written document for medical staff. There needed to be in place, on the beginning of every six-monthly medical rotation, a written and retained list of abbreviated signatures and initials so that each medically signed or initialled entry could be identified to its designator. This applied with equal force to both prescription writing and medical case note entries.

There were, it was reported, management team meetings on a regular basis, with minutes kept. A similarly positive reply was given to enquiries concerning fire and safety committees. There was an induction and training process for intake nursing staff, including a two-day rotation by a number of senior staff members. The Inspectorate was unable to establish whether a medical equivalent existed. Neither was it clear that written information for patients on their prescribed treatments was presented to them on prescription.

With the exception of Kelvin Grove, the wards in St Dymphna’s Hospital were clean and well maintained; some of them had been painted fairly recently. Patients had easy access to open air in the grounds, which were well maintained. There was a shop in the hospital which catered for their basic needs. There was central reporting of incidents and assaults on patients and staff; this was inspected and found to be generally satisfactory. A new reporting form had been issued recently by the SEHB, dealing with accidents, incidents and near-miss episodes, which was coming into use. A multi-speciality nursing group had prepared a report on best practice guidelines for record keeping. However, this otherwise useful document did not deal specifically with the issue of the setting up of the identity of initials and scripted or other signatures by staff members. It was the Inspectorate view that this should be undertaken whenever a new staff member joined the service, whether nursing, medical or other. The purpose of this, of course, was to identify, should need arise, who prescribed what drug, who administered it, or who made what case note entry.

The community residences in Carlow town, supervised and unsupervised, were visited — there were none elsewhere in the county. Of these, Beechwood House had opened only the day before. Its residents had moved from Sacred Heart House, which had the previous day received eight intellectually disabled persons who, themselves, had transferred from another house, Elm Court, a rented premises that had just been given up. All these residences were in good repair and decorative order; all had adequate fire-safety systems, were equipped with telephones, and residents knew what numbers to contact in case of emergency. All community residents attended one or other of the occupational training centres during the day. The nursing staff attached to Clann Nua maintained a watching brief on community residences.

The Inspectorate was struck by the substantial nursing staff provision of 126 posts for a catchment area population of 42,000, and the relatively expensive cost of this service, at approximately €13 million per year. With such a relatively lavish staff resource, it should have been possible to devise extensive community-based outreach services providing assertive outreach and home-care interventions.

RECOMMENDATIONS

It is recommended that:—

1. The psychiatric unit in St Luke’s Hospital, Kilkenny, be opened as soon as possible.
2. Coincident with this opening, St Dymphna’s Hospital be de-designated and specialised services be put in place for the intellectually disabled, older persons, and rehabilitation provision for the joint catchment area.

3. A day hospital premises, to incorporate a community mental health centre, be provided in Carlow town.
4. The substantial human resource complement, particularly in nursing, in Carlow be orientated towards assertive outreach and home-care intervention.

KILKENNY MENTAL HEALTH SERVICE — 2002 INSPECTION

INSPECTED ON 8 AUGUST, 2002

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 60,300 was divided into three sectors as follows:

Sector	Population
Kilkenny East	20,100
Kilkenny North	20,100
Kilkenny West	20,100

IN-PATIENT CARE

In-patient care was provided at St Canice’s Hospital, which had ninety-two beds.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	—	10	12	5	5	32	41.56
3 to 12 Months	—	—	—	—	3	3	6	7.79
1 to 5 Years	—	—	1	6	5	8	20	25.97
Over 5 Years	—	—	—	4	4	11	19	24.68
All Lengths of Stay	—	—	11	22	17	27	77	100
% of Total	—	—	14.29	28.57	22.08	35.06	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
12	27	—	15	5	5
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
2	3	1	7	—	77

Status of In-Patients on the date of inspection 2002

Status	Male	Female	Total
Voluntary	22	23	45
Temporary	1	2	3
P.U.M.	1	—	1
Ward of Court	—	—	—
Total	24	25	49

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
411	6.85	78	18.9	91.25	8.75	437	12

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of Persons Attending
Day Hospitals	1	15	27
Day Centres	6	100	88
Out-patient clinics	8	228*	899

*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
7	31	—	—	6	83

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
7	10.5	155	67	7

COST

The cost of the Kilkenny Mental Health Service was €11.58 million in 2001.

GENERAL COMMENTS

It was a disappointment to the Inspectorate to learn that the psychiatric unit in St Luke’s General Hospital for the Kilkenny and Carlow mental health services, which were being amalgamated in a unified catchment area of approximately 114,000 population, had not opened. The 2001 Inspector’s report recorded that an attempt had been made to requisition the unit on a temporary basis for general medical purposes. This had been resisted on the understanding that the unit would be taken over and functioning early in 2002. There were a number of reasons, it was reported, why this had not happened. The nursing

representative organisations had insisted that certain structural changes be undertaken before they would allow their members to move. These included the covering in of the nurses' station in the acute observation area and for padding/cladding of one or other of the secure rooms (which was in fact a request by the consultant psychiatrist). It was the opinion of the Inspectorate that neither of these measures was necessary. The Inspectorate was informed that the staff canteen facilities in St Luke's Hospital were already stretched to the point where no further staff could be accommodated. Accordingly, the nurses' unions were insisting that space be provided in the unit for staff dining. Due to a lack of storage space for medical records, agreement has been reached with St Luke's Hospital to provide a space within the central filing areas for medical records from the Department of Psychiatry. Finally, because of perceived accommodation inadequacies in the current accident and emergency department, it was now believed necessary to site a referral/drop-in assessment facility within the psychiatric unit itself. It was unclear why none of these difficulties had been identified and dealt with at planning stage. It was reported that matters would be attended to and that the unit would open in November 2002. Given that, at the time of this visit, no steps had been taken to undertake any of the necessary work involved, the Inspectorate was sceptical that the unit would open this year.

It was, in the Inspectorate's view, quite unsatisfactory that dining provision should be made for staff on the unit. The Inspectorate was likewise unhappy with the arrangement of having all persons, either other-referred or self-referred coming into the unit for assessment. It was claimed that this would be a temporary measure and that when an enlarged accident and emergency department was available in St Luke's — and planning, including psychiatric provision, had already begun — this proposed temporary arrangement would cease. The perceived necessity for it also underlined the lack of a mental health centre or day hospital provision in Kilkenny city or elsewhere in the county.

The Inspectorate was struck by the illogical arrangement of the close-observation component in the new psychiatric unit at St Luke's Hospital. The nurses' station, which was to be glazed in, was isolated from patient interchange and overlooked two single rooms. However, beyond and behind these two rooms were two further single rooms, also intended for acute observation, which were unobservable from the nurses' station.

A specialised service for later-life psychiatry was to be established in a matter of weeks, with the arrival of a consultant to lead the specialised team. However, while continuing care beds would be available in the refurbished St Luke's/St Gabriel's accommodation in St Canice's Hospital, no physically separate unit for acute assessment had been included in the design of the unit in St Luke's. Another specialist innovation in the service had been the dedication of a registrar, under consultant guidance, to rehabilitation. A new clinical director for the joint Carlow/Kilkenny service had been appointed just prior to this inspection. The absence of a community-based mental health centre/day hospital in the Kilkenny or Carlow services was a serious deficiency. Currently, patients came in to both St Dymphna's and St Canice's to what was called a day hospital facility, but in neither case was this designation justified. Effectively, both operations lay somewhere between a day centre and a drop-in social centre facility. The consequence of this was the inability to assess and treat patients in a community setting, with resultant over-reliance on acute

admission beds. In the case of St Canice's, this was compounded by patients flooding into the hospital on a daily basis, not just for 'day hospital' purposes but also for administration and monitoring of Clozapine and Lithium. As if this were not enough, alcohol withdrawal or detoxification was also carried out on an ambulatory basis in the so-called day hospital in St Canice's. Finally, out-patient clinics were held in the same day hospital premises for community residence and group home residents. These operations, currently five-day, were to be extended to a seven-day a week activity. All of this illustrated once again the almost complete absence of appropriate community-based services in Kilkenny city and county.

On a more positive note, it was pleasing to note that the St Gabriel's intellectual disability unit at St Canice's had closed and the former residents there had been transferred to suitable accommodation at the former Kilcreene Hospital. It was now envisaged that the former St Gabriel's would become part of the care of older persons provided in St Canice's; work would shortly start in St Gabriel's to this purpose. Sixty per cent of the eighty-nine patients in St Canice's Hospital were aged over sixty-five years and one-third were over seventy-five years on the day of this inspection. The remaining two components of St Canice's patients comprised a small number of younger long-stay patients and acute admission patients distributed in two admission wards. The case for the de-designation of the two conjoint St Luke's/St Gabriel's complexes for older persons in St Canice's was unanswerable and the linkage of the care of these patients with the general services for older persons in the county should be proceeded with. This was all the more logical and plausible because the patients in the existing St Joseph's ward, most of whom were older persons, would shortly be transferred to the St Luke's/St Gabriel's complex and the St Joseph's ward premises was to be handed over to the services for older persons. The setting up of a later-life psychiatry service would enable close co-operation between this new service and the expanded general health service for older persons to take place, with benefit to both.

The current admission facilities in St Canice's, particularly Admission B, underlined the urgent necessity of moving to the new psychiatric unit in St Luke's Hospital as soon as possible. The absence of an enforced admission policy had led to an over-reliance on acute admission, as distinct from community assessment, treatment and support. Of the ten patients in Admission B at the time of inspection, approximately half were there for alcohol detoxification. The Inspectorate saw no reason why this process should not take place on a domiciliary, primary-care or GP-care basis, or, if severe, in the general medical wards in St Luke's. In fact, one of the five had been transferred to the medical ward because of the severity of his withdrawal symptoms.

Similarly to the Carlow service, that of Kilkenny was plentifully endowed with nurses. The Inspectorate was unable to ascertain what proportion of these worked in a community setting. It was quite evident that assertive outreach, domiciliary-based approaches were neither comprehended nor operating in this service. It was essential, as already stressed, that a re-orientation towards community care of a comprehensive nature be undertaken.

While there were approximately two occupational therapists and two psychologists in place in this service, there were no social workers. Thus, the multi-disciplinary element of

the service needed attention. In the admission areas, case note structure was of a reasonable nature but reception entries did not give a clear account of pre-admission assessment, the paths to referral, whether the assessing doctor had consulted with a consultant (quite often he or she had not, the Inspectorate was informed), and why admission, rather than some less restrictive approach, was deemed to be necessary. While there was written evidence that most admissions had been seen by a consultant within twenty-four hours, a clear programmed approach to care was not outlined. Nor was there any evidence that patients themselves were involved in the care plan being evolved for them. The absence of ICD numerical diagnoses in case notes, particularly on top sheets, was also evident. In one case where a temporary patient reception order had been extended there was no medical entry to indicate that this had happened, and in another, while there was such an entry, the reason why an extension of involuntary, rather than a conversion to voluntary, status was not indicated.

Seclusion was not employed in the service: special nursing was used. In one case, a patient had received special nursing continuously by day over a period of one year. It appeared to the Inspectorate that this patient was misplaced and, having suffered brain damage from a road traffic accident, required the specialised care of a continuing brain injury rehabilitation unit.

Notices were on display in all units informing patients of their rights under the Mental Treatment Act, 1945 and otherwise. A complaints procedure was in place and notices were displayed in the units indicating the steps patients should take should a complaint arise. However, no clearly and unambiguously identified complaints officer was mentioned by name in any of these notices. A brochure for newly admitted patients was available and was distributed to them. A number of such patients were interviewed to ascertain their views of the service provided to them. Some patients in Admission A were dissatisfied with the frequency with which they saw their consultant and, in one case, unsure of whom the designated consultant was. Some seemed uncertain about the type of medication they were receiving, its purpose or its side effects. Others had some understanding of their psychiatric condition and the need for treatment. Patients were generally satisfied with the no-smoking arrangements and with the general comfort of the unit, although some criticised the available day space in Admission B. Patients were generally happy with storage space for clothing, facilities for washing, and the respect for privacy. Some were confused about the existence of a primary nurse designated to them; this was not helped by the fact that most staff did not wear identification badges. Food was generally felt to be adequate, even in the absence of a rotating and displayed menu. Generally, patients gave the impression that they were not involved in their own treatment plans although, in some cases, these were explained to them; their role here was passive, rather than active. Some complained of boredom during the day and felt they did not get sufficient opportunity to engage in occupational or activational activity.

Management meetings took place in the Kilkenny mental health service on a regular basis, though it was apparently a number of months since the last one had taken place. The numbers attending these meetings seemed to the Inspectorate to make the process

unwieldy, with up to twenty individuals present. The Inspectorate was told that the meetings were chaired and minuted. In addition, there were joint Carlow-Kilkenny management meetings relating to the integration of the two counties as one catchment area. There did not seem to be regular fire-safety committee meetings and the issue of the existence of a safety committee appeared vague, so that it was not possible to ascertain when the last meeting of such a committee took place.

A system of reporting and documenting incidents, accidents and assaults was in place and a record book was kept documenting each such episode. There was a general policy and procedure manual that included information on policy and procedure in relation to patients being absent without leave. It was reported that the procedures in relation to this were activated whenever such an occasion arose. There did not seem to be any policy on the searching of a patient's belongings or person in relation to alcohol, drugs or dangerous weapons when there was any suggestion that these might be present. It was not clear when the last safety audit had taken place.

There was a designated ECT consultant and the nursing officer in charge of Admission A was, the Inspectorate was told, responsible for ECT. There was an induction process for nursing staff and training and education on CPR, lifting, and other aspects of day-to-day nursing procedures. The SEHB had produced a report on nursing documentation, including the use of abbreviations. It was not clear whether either nursing or medical staff were obliged to provide signatures opposite names for documentary identification purposes. Many prescriptions were medically signed by initials only and some could not be identified to the prescriber.

The general level of decoration and furnishing in the St Canice's Hospital wards was satisfactory, although inadequacies as identified in the body of this report were evident in the admission wards particularly. However, the St Canice's entry area had been painted in bright colours and generally presented an acceptable face. The grounds were reasonably well kept and adequately signposted. St Luke's ward had been upgraded, with the creation of a new nurses' station that was used by day and, with the shutting of St Brigid's ward, the opening of a smaller unit in St Luke's for the care of physically ill older persons, which provided a good level of comfort and observation.

There were four high-support community residence facilities in Kilkenny, all within reasonable reach of St Canice's, some of which had been newly provided or upgraded. In general terms, they were well maintained, furnished and decorated. Most of the residents in them came back into St Canice's for occupational or activational purposes, mainly to the industrial therapy unit, which provided a range of activities. The Inspectorate was happy to hear that the newly designated rehabilitation registrar working in concert with a consultant was reviewing the medical and social profile and needs of those in community residences with a view to adjudicating on whether these were best met by existing or alternative provision.

RECOMMENDATIONS

It is recommended that:—

- 1. The psychiatric unit in St Luke’s Hospital open as soon as possible.
- 2. Community-based day hospital/community mental health premises be acquired for all Kilkenny sectors, and particularly in Kilkenny city, to put an end to the highly undesirable practice of centralising all these activities in St Canice’s Hospital.
- 3. A comprehensive and integrated programme for older persons be put in place, in conjunction with the generic services for older persons in the county, and the newly established, specialised later-life psychiatry services.

TIPPERARY MENTAL HEALTH SERVICE — 2002 INSPECTION

INSPECTED ON 8 MAY, 2002

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

IN-PATIENT CARE

Acute in-patient care was provided at the forty-nine bed St Michael’s Unit in St Joseph’s Hospital, Clonmel, and long-stay in-patient care was provided at St Luke’s Hospital, Clonmel, which had 174 beds in three male, two female and two integrated wards.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	2	26	18	4	7	57	26.8
3 to 12 Months	—	—	9	7	1	1	18	8.5
1 to 5 Years	—	—	4	12	4	8	28	13.2
Over 5 Years	—	—	10	58	17	24	109	51.5
All Lengths of Stay	—	2	49	95	26	40	212	100
% of Total	—	0.95	23.1	44.8	12.3	18.9	100	

In-Patient Population Diagnosis (31.12.01) — St Michael’s Acute Unit

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	4	—	17	5	—
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
1	7	6	—	5	45

In-Patient Population Diagnosis (31.12.01) — St Luke’s Hospital, Clonmel

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
9	57	8	8	16	1
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
3	2	5	33	25	167

Status of In-Patients on the date of inspection 2002 — St Michael’s Acute Unit

Status	Male	Female	Total
Voluntary	18	21	39
Temporary	8	4	12
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	26	25	51

Status of In-Patients on the date of inspection 2002 — St Luke’s Hospital, Clonmel

Status	Male	Female	Total
Voluntary	89	70	159
Temporary	2	2	4
P.U.M.	3	1	4
Ward of Court	3	2	5
Total	97	75	172

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
1,119	8.25	227	20.3	88.7	11.3	1,117	10

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of Persons Attending
Day Hospitals	5	78	1,120
Day Centres	4	63	195
Out-patient clinics	13	558*	1,877

*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
11	39	3	22	1	19

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
10	23	190	69	7

COST

The cost of the Tipperary Mental Health Service was €15.24 million in 2001.

GENERAL COMMENTS

Substantively, there had been no changes in the Tipperary Mental Health Service since the last inspection. However, the Inspectorate was assured that the long-awaited initiatives in Cashel were about to be put into action. Specifically, work was about to begin on the creation of a twelve-place, high-support community residence and a residential unit for a similar number of intellectually disabled persons, both in Cashel. The expectation was that these premises would be ready for occupation approximately eighteen months from the time of this inspection. There was a plan to provide residential accommodation for a further number of intellectually disabled persons and a further unit for older persons suffering from organic brain disorder, in addition to a day centre for mentally ill persons, on a site on the St Luke’s Hospital campus. This site was called St Damien’s and would also accommodate other care elements, such as social housing. Additionally, the current day centre adjacent to Morton Street in Clonmel town would move to a location adjoining St Damien’s. As a consequence of the rehousing of intellectually disabled persons currently resident in St Luke’s at both the Cashel and the new Clonmel locations, St Paul’s ward in St Luke’s would close. Following closure, the ward would be adapted to care for older patients currently in St Luke’s and would be de-designated. Further internal re-arrangements in St Luke’s Hospital would lead to the imminent re-opening of the renovated St Teresa’s ward within the original hospital building to accommodate patients from St Catherine’s ward, whereupon the space currently occupied by St Catherine’s would be converted to resource centre and office use.

The Inspector’s Report for 2001 welcomed the setting up of a consultant-led psychiatric service for the older persons. This service had now been given the necessary personnel to

carry out its work and a newly decorated two-storey house, called Rose Hill, within the St Luke's complex had been made available to serve as the headquarters of the service and to provide a small day centre facility.

The day centre premises, newly constructed at St Vincent's Hospital in Tipperary town, had begun operation earlier in the year.

A crucial issue in this service, as in others, was the establishment of mental health centres, sector headquarters and day hospitals in each sector, providing outreach services and enabling responsive and reactive multi-disciplinary access for the consumer and, most importantly, providing primary care services for assessment and crisis purposes. To a large extent, these resources did not exist in the Tipperary mental health service and the Inspectorate was not convinced that the existing sectorisation arrangement was appropriately aligned for this purpose. The Inspectorate would therefore suggest a reconsideration of the current sectors, with particular regard to centering them on appropriate population centres and identifying within them the urban centre most appropriate for such development. While there were embryonic structures in Tipperary town and parts of Clonmel, the physical infrastructure needed to enable care delivery 'in the community' was needed in Cashel and Carrick-on-Suir. With the passage of Tipperary North Riding to the Mid-Western Health Board, the establishment of similar community-based structures in Thurles and Nenagh became the responsibility of that health board, although in-patient care for North Tipperary was still provided in Clonmel. The Inspectorate felt that persons from North Tipperary needing in-patient care should be catered for in the psychiatric unit of Limerick Regional Hospital.

Community developments as outlined above were vital and urgently needed in the Tipperary mental health service. As it was, this service was very largely institutionalised, with one of the highest residence and admission rates of any service in the country. The current fifty-bed admission unit, called St Michael's and regarded as being part of St Joseph's General Hospital, although physically separate from it, was virtually always full. As a result, overflow patients were directed to locked accommodation of poor quality and intimidating atmosphere in St Luke's Hospital. This was a practice and an experience for patients that could not be condoned. It appeared that no appropriate admission policy operated in St Michael's unit and that virtually all patients who presented themselves there, irrespective of their need, were automatically admitted to the hospital and that the decision to admit was usually made by junior doctors. In addition, some patients who, on admission to St Michael's, were perceived as management problems simply because they were judged behaviourally difficult, or patients who did not wish to stay in the unit, were also transferred to locked accommodation in St Luke's, and were often secluded in the wards, notably, St John's, to which they were transferred.

It was widely acknowledged that St Michael's unit was unsuited to its function by reason of its structure, layout, lack of adequate observation areas, and poor decoration. Accordingly, a project team had been convened to plan a replacement unit. During this inspection, the Inspectorate met with the project team and indicated the number of beds it

considered appropriate for the provision acute in-patient care in the reduced catchment area of approximately 85,000, in the setting of a comprehensive mental health service.

The current arrangements in St Luke's Hospital were quite unsatisfactory and the Inspectorate had adverted to its unhappiness with them in the past. Once again, it was necessary to point out that the mixture of intellectually disabled persons and persons suffering from mental illness in the same ward was quite unacceptable and militated against the care of both groups. In the case of St John's and St Bridget's wards, this problem was compounded by the transfer of newly admitted patients to these wards, which was most unsatisfactory. The Inspectorate was aware that there were plans to provide new facilities for the intellectually disabled, but these would take several years to realise. In the meantime, there did not appear to be any reason why persons with intellectual disability currently in St Luke's could not be provided for as a group in one specific area of the hospital simply by the rearrangement of wards. It was noted that approximately forty per cent of St Luke's residents were older persons, requiring the care of later-life services, rather than those of mainline psychiatry, and they too should be cared for in de-designated premises and their physical needs looked after by primary care physicians. The Inspectorate was concerned at the high level of seclusion in St Luke's and the fact that most of this was prescribed by junior doctors, often for considerable periods of time. Additionally, the rooms in which patients were secluded were neither safe nor attractive. It was a matter of concern too, that, though protocol and detailed arrangements appeared to be in place for the transfer of patients from the admission unit, St Michael's, to the main body of St Luke's Hospital, or for the direct admission of patients to that hospital, newly admitted patients were, in some instances, not seen by a consultant for up to a week following admission, as judged by case note entries. Case note composition and structuring and usage were unsatisfactory and it could be difficult for a third party, such as the Inspectorate, to determine with any accuracy when a patient was admitted or discharged. The sequencing of case note entries and the mixture of laboratory reports with medical case note entries added to the confusion and non-sequential nature of case note layout.

The virtual absence of any meaningful occupational or rehabilitative activity for long-stay patients in St Luke's was striking once again on this inspection. It was reported at our preliminary pre-inspection meeting that two consultants would take a special interest in rehabilitation. It was pointed out that this was basically an unsound arrangement and that responsibility for rehabilitation, whether as a full-time or special interest, should be assigned to one consultant and his or her team.

It was noted that comparatively few nurses worked outside the institutional base in the Tipperary service, and this despite a relatively generous ratio of nurses to catchment population. Apparently, because of recent remuneration arrangements, many staff were reluctant to 'move to the community' and preferred instead to spend their professional lives in outmoded institutional practices.

There were currently four psychologists in the service we were told, but no social workers or occupational therapists, although attempts were being made to recruit suitable persons to these established posts.

Forty-five patients were placed in seclusion at St Michael's Unit and a further twenty-seven at St Luke's Hospital in 2001. Between both locations, there were a total of 209 episodes of seclusion during the year. There were fourteen episodes of seclusion in St John's ward, all for periods of twelve hours, involving six patients, up to the date of inspection in 2002. Most seclusion authorisations were by junior doctors. It was not possible to check the medical notes of these patients at St John's ward as they had transferred to other locations. However, a seclusion register was maintained and fifteen-minute nursing records of all observations of patients placed in seclusion were recorded. The seclusion room was not safe. It was of poor quality, with graffiti on the walls, which had projecting hooks. Access to the seclusion room was through the ward corridor. The room itself required redecoration. There were fifteen episodes of seclusion in St Bridget's ward, involving five patients. Again, seclusion was for long periods and seclusion authorisations were, for the most part, by junior doctors. Doctors authorising seclusion should use their signature in full. There was a need for a regular audit of the use of seclusion in this service. Twenty-six patients were placed on one-nurse-to-one-patient special nursing supervision during 2001 and there were 200 episodes of special nursing supervision involving duty spans of twelve hours or more.

There were no recorded complaints made by patients or patients' relatives to the local complaints manager in 2001. Six requests for information under the Freedom of Information Act were made during the year and all appeared to have been dealt with satisfactorily. There were no research projects undertaken in this service governed by the Clinical Trials Act 1987-1990.

Twenty-nine patients were prescribed ECT treatment in 2001 and the procedure was administered to patients with their fully informed, written consent. The written protocol for the administration of ECT and the treatment facilities, incorporating waiting, treatment and recovery rooms, were all satisfactory. The ECT fact-sheet from the Royal College of Psychiatrists was used as an information leaflet for patients and their families.

There were thirty recorded accidents to patients and thirty-five recorded accidents to staff in the Tipperary mental health service in 2001. Six of the patient accidents and six of the staff accidents were deemed serious. Information relating to the number of assaults on patients by other patients and assaults on staff was not available at the time of inspection. There was a need to audit the accident and incident reporting system, with a view to producing an annual report relating to accidents and assaults by date, time and location.

There were 127 temporary admissions to this service last year. Five patients had their temporary admission orders extended during the year. Sixty-three patients took their own discharge from the service against medical advice in 2001. Procedures were in place to follow up all patients if deemed clinically appropriate.

The written policy for ordering, prescribing, storing and administering medicines should be reviewed and updated. There was a need for written instructions on the use of prescription cards. All prescriptions should be signed and dated individually and contain the signature in full of the prescriber. While a register was maintained of full signatures of nursing

staff and initials used on the drug administration recording card, provision should be made for the nurse's signature in full when next this card is printed. There was an increased risk factor of drug error if discontinued prescriptions were greater in number than current prescriptions, and this was noted in a number of locations. The transport system and the storage area for medicines in the clinical wards were satisfactory. There was a hospital brochure for patients with pertinent information relating to their stay in hospital and notices on patients' rights under the Mental Treatment Act, 1945 were prominently displayed in the clinical areas. Information relating to the local complaints procedure was not readily available to patients and should be either prominently displayed at ward locations or included in the hospital brochure, with the name of the local complaints officer. Patients had adequate access to a shop and access to fresh air, either supervised or unsupervised. Emergency resuscitation equipment was appropriately located and checked regularly, with records kept of all checks to ensure equipment functioned properly and medications were within current date.

The management team of this service met on a monthly basis and minutes of management team meetings were kept. There was a fire committee, which met annually. There was no safety committee in existence in this service. Safety statements in the ward areas were generic statements for the SEHB and were undated. The Inspectorate was informed that all safety statements in the local areas were under review at the time of this inspection. The local system for reporting and documenting incidents, accidents and assaults was satisfactory, but there was a need for a safety audit. Copies of safety audits should be kept at each local area, indicating the various hazards identified and the name of the person responsible for ensuring these matters were attended to. There was an induction process for staff, using the regional staff handbook. While records were kept of the induction process for junior doctors, it was recommended that records be kept of the induction process for all staff, stating the name of the staff inducted, the name of the supervisor and the general description of the induction process.

The toilets and bathrooms were generally clean, but some were of a poor decorative standard and required refurbishment. Mirrors, soap and towels should be provided for patients at St Mary's ward. Clothing for patients was not personalised in all wards. All patients should have individualised, personal clothing, including night attire and toilet requisites.

Designated smoking areas were not provided at all locations and this matter required attention. There was evidence of smoking in bedrooms at some locations and this should be actively discouraged. The Inspectorate was pleased to note that this service did not issue tobacco products to patients. Patients had access to the local shop to purchase same, if necessary.

The patients' money-management system within this service appeared satisfactory. An information sheet was sent to patients on admission informing them of hospital charges. New clinical files had been introduced to the later-life psychiatry services for the South Tipperary area, containing a special form for mental health assessment, which was quite comprehensive, and also a special form for mini mental state examination and a number

of other assessment forms, such as the Hamilton Psychiatric Rating Scale for depression. This was welcomed. Written instruction on the filing of documentation within the medical records was required for all medical notes in the Tipperary service. Each newly admitted patient had a full medical evaluation, including comprehensive admission notes, mental state examination, physical examination and clear immediate management plan recorded in all medical notes examined. While there was provision for the recording of the patient's name on each continuation page, this had not always been recorded. There was considerable storage of loose clinical material within the files of the adult mental health service. Risks associated with this included delays in accessing pertinent information, and lost or misfiled information. All clinical material should be securely stored within the medical file. The new patient assessment form for the adult mental health service was comprehensive and, on checking notes at random, appeared to have been completed satisfactorily. Since the last inspection, records were being kept of all patients presenting for assessment at St Michael's acute unit. The records contained the name of the patient, date of assessment, referring party, assessing doctor, reason for assessment and summary of intervention or advice given. Ideally, most of these out-patient assessments should take place at acute day hospitals and not at the acute in-patient unit. Three patients were on the waiting list for admission following assessment at St Michael's. Two had a diagnosis of alcohol dependence, and one a diagnosis of mania.

There was a written policy and procedure relating to patients absent without official leave. This policy was dated 1992 and required some review and updating. There was a grid map of the grounds, which was under review at the time of inspection, to facilitate a local search for a missing patient in conjunction with St Joseph's Hospital. The policy contained information as to when and who should contact the Gardaí and patients' relatives, which was satisfactory. The revised policy should state clearly who was to take charge of the absent without official leave procedure, and some information should be contained within the policy relating to the responsibility of various personnel relating to returning the patient to the unit, once located. The existing procedures and policy manual was undated, but the Inspectorate was informed that all policies and procedures were under review. There was a need for written policies on patients' voting rights, locking of external ward doors, searching patients and patients' belongings, and guidance on the management of illicit drug use and drug-related incidents. In addition to the revision of the existing policies, there were policy standards relating to personal clothing, incontinence, skin treatment and protection, and patients' privacy and dignity at a number of wards. All were undated. There was a system of review, but this had not been completed.

RECOMMENDATIONS

It is recommended that:—

1. The various components of the Cashel initiative be progressed as soon as possible.
2. The St Michael's Unit be replaced by an up-to-date, modern unit suitable for acute admission purposes.
3. The mix of patients in some of the long-stay wards be reviewed.
4. Additional high-support residential accommodation be provided.

- 5. Efforts be made to improve the overall appearance of the grounds surrounding Edel Quinn house.
- 6. Personal clothing be introduced for all patients.
- 7. Site-specific safety statements be made available at each clinical location.
- 8. An up-dated policy and procedure manual be made available in each clinical location for staff information and reference.

WATERFORD MENTAL HEALTH SERVICE — 2002 INSPECTION

INSPECTED ON 3 JULY, 2002

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 106,529 was divided into four sectors as follows:

Sector	Population
West Waterford	29,843
Mid Waterford	29,843
East Waterford	29,843
South Kilkenny	17,000

IN-PATIENT CARE

In-patient care was provided at St Otteran’s Hospital, which had 133 continuing care beds, and at the Department of Psychiatry, Waterford Regional Hospital, which had forty-five beds in an acute unit.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	1	15	9	4	5	34	21.6
3 to 12 Months	—	2	8	14	4	8	36	23.0
1 to 5 Years	—	—	4	3	7	20	34	21.6
Over 5 Years	—	—	4	19	17	13	53	33.8
All Lengths of Stay	—	3	31	45	32	46	157	100
% of Total	—	1.9	19.7	28.7	20.4	29.3	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
26	36	12	31	18	3
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
8	10	—	9	4	157

Status of In-Patients on the date of inspection 2002

Status	Male	Female	Total
Voluntary	60	78	138
Temporary	9	6	15
P.U.M.	—	—	—
Ward of Court	1	4	5
Total	70	88	158

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
780	7.32	297	38.07	92	8	775	13

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of Persons Attending
Day Hospitals	1	20	478
Day Centres	3	60	218
Out-patient clinics	6	455*	Not specified

*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
12	56	2	11	3	37

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
9	12	149	49.6	8.6

COST

The cost of the Waterford Mental Health Service was €9.8 million in 2001.

GENERAL COMMENTS

There had been little change in this service since the inspection of 2001 and the need for clearly envisaged progress remained outstanding and still dependent on capital investment.

Many issues revolved around St Otteran’s Hospital and its future. On the day of inspection there were 120 patients in the hospital, of whom seventy-two were over sixty-five years and forty-four were over seventy-five years. The predominantly older-age population of St Otteran’s was explained mainly by the ageing of the long-stay population, but also because of the admission of older patients to the continuing care ward, St Aidan’s. Patients were admitted to this unit as part of the overall later-life psychiatry service, which had been recently established in the service, either, on transfer from the six acute assessment beds in the Department of Psychiatry of Waterford Regional Hospital or by direct admission from other sources. However, this number was comparatively small and amounted to thirteen so far in 2002. St Aidan’s was one of five wards remaining in St Otteran’s. One of these was a locked ward for male patients regarded as being difficult to manage and in need of relatively high support. An opportunity had now opened up for the replacement of St Enda’s at the former campus-based RMS’s house, which, without massive capital expenditure, could be converted into an acceptable high-support residence. This would lead to the closure of St Enda’s. The great majority of the remaining patients required the services of non-psychiatric care for older persons. These included all the patients in St Monica’s and St Joseph’s. The younger patients in the remaining ward, St Clare’s, should be the concern of a specialised rehabilitation service. With these initiatives, St Otteran’s could close.

On the community side, there was an urgent need for enhanced day hospital and day centre facilities, particularly in Waterford city, to relieve the overburdened existing provision at Brook House. Further community-based residences were necessary to augment the proposed rehabilitation service. Clearer identification of sector headquarters to provide multi-disciplinary working sites in the sectors was also required and, although the social work, psychology and occupational therapy components of the service had been put in place in recent years, these needed strengthening in the numerical sense.

There were thirty-three patients in the Department of Psychiatry, Waterford Regional Hospital, twelve males and twenty-one females. Eighteen female and eight male patients were of voluntary status, and three female and four male were temporary patients. One hundred and twenty-five patients were resident at St Otteran’s Hospital. Five were Wards of Court, four female and one male, and eight were temporary patients, three female and two male. There were sixty-three temporary admissions to the Waterford mental health service in 2001 and eight extensions of involuntary admission.

In order to provide greater privacy for patients in St Enda’s Ward at St Otteran’s Hospital, individual curtain screens should be provided for each bed in the dormitory area. The facilities for visitors should be improved to afford greater privacy for patients and visitors.

There was no designated smoking area in this ward. This should be provided and all other areas deemed non-smoking. All furnishings with torn upholstery should be replaced, as they constituted a fire hazard. While there was a panic alarm provided for the protection of staff at the St Enda's unit, a written policy and procedure on its use should be available for staff information and reference.

There were thirty-nine episodes of seclusion in 2001, involving eighteen patients. Access to the seclusion room was off the corridor adjacent to the nurses' station. This afforded only reasonable privacy for patients. The room furnishings were satisfactory. The seclusion register was appropriately maintained and fifteen-minute nursing observations appropriately recorded. Some seclusion authorisations were by junior doctors and some signatures were illegible.

An interview with a patient in the secure area in the Department of Psychiatry, Waterford General Hospital, revealed that he was unhappy about being locked up all day, without access to the common dining room or to the OT department. He had also been deprived of his clothes, a measure which was continuing and which he resented. He was otherwise happy with aspects of his care, including the staff relationships and his medical treatment, and had had this treatment, his care plan and his medication and the reasons for it, and its side effects, explained to him. There was a partially enclosed garden courtyard area within the precincts of the unit. It was not accessible to patients and the Inspectorate felt that, with a little bit of imagination and money, it could be so re-ordered as to be integral with the unit, particularly the acute component of it, and would greatly enhance patient comfort.

Policies and procedures to assist staff make decisions about clinical and administrative matters relating to the appropriate care of patients and the needs of staff providing that care were all under review at the time of this inspection. Revised policies, when updated, will provide a framework for a consistent approach to care and enable staff make decisions with guidance and support. New policies and procedures should be formally introduced to relevant staff, ensuring awareness and understanding of content, and records of this should be kept locally.

Two patients were placed on special, one-nurse-to-one-patient, supervision and there were fifteen episodes of special nursing supervision involving duty spans of eight hours or more. The policy and procedure on special nursing supervision and prescribed recorded observation was under review.

The South Eastern Health Board operated a smoke-free policy and smoking was not permitted in the hospital units, other than in designated areas. This policy was adhered to, but there was a need to improve the designated smoking facilities for patients at a number of locations. The patients' money-management systems appeared satisfactory. A formal system should be in place to ensure patients were informed of hospital charges. This could be included in the comprehensive patient information booklet when next reprinted. Service providers ensured that appropriate information was given to patients about their legal position and rights under the Mental Treatment Act, 1945. The giving of

information on rights to detained patients should be adequately recorded in clinical notes. The standardised form currently in use could be amended to include space for recording the name of the person giving the information; the date the information was given, whether the patient understood the information, and subsequent attempts to give the information.

The arrangements for ECT at the Department of Psychiatry, Waterford Regional Hospital, were very satisfactory. The dedicated ECT suite comprised separate rooms, including waiting, recovery and treatment rooms. A named consultant psychiatrist was responsible for the ECT clinic and there was an appropriate induction process for all new doctors. The consent form and pre- and post-ECT nursing checklist were comprehensive and completed satisfactorily. Sixty patients were prescribed ECT in this service in 2001.

There were three recorded complaints made by patients or patients' relatives to the local complaints manager during 2001 and all appeared to have been dealt with satisfactorily. Guidelines were available for staff on the handling of patients' and relatives' complaints. Management should periodically closely monitor the handling and outcome of local verbal complaints to note any quality implications arising from the complaint.

There was a written policy for the ordering, prescribing, storing and administering of medicines. The drug prescription card had provision for recording of drug allergies so that information was rapidly available to staff. The storage area and transport of medicinal preparations at Department of Psychiatry, Waterford Regional Hospital required review. Prescription cards examined at random had each prescription signed and dated individually, but some signatures were illegible. The discontinuation column of some prescription cards was not always completed, with one signature in full and one date for each drug discontinued. There was an increased risk factor of drug error on a number of cards where discontinued prescriptions were greater in number than current prescriptions, and this required review.

Management team meetings were held on a monthly basis and appropriate minutes were kept. The fire and safety committee had met in the six months prior to this inspection and there was a health and safety audit of ward areas four months prior to this inspection. A formal induction process for all new staff at the Department of Psychiatry should be introduced. Emergency trays and equipment were appropriately stored at strategic locations within St Otteran's Hospital. A system of checking medications to ensure they were within date, and checking equipment to ensure it was in working order, should be introduced in St Monica's Unit, and appropriate records kept. The checking system in the other units was satisfactory.

There were 173 accidents to patients and twenty-six accidents to staff at St Otteran's Hospital in 2001, and eighty-seven accidents to patients and three accidents to staff at the Department of Psychiatry, Waterford Regional Hospital. One accident to staff was deemed serious, others resulted in minor injury or no injury. There were seventeen assaults on patients by other patients and seventy-four assaults on staff in the entire Waterford mental health service in 2001. None of the assaults were deemed serious; three of the

patient assaults and seven of the staff assaults resulted in minor injury — scratches, bruises, etc.

From an examination of nursing notes, it appeared that entries were made as soon as possible after events to which they related. Nursing records were written clearly so that text could not be erased and were easily readable on photocopies. All records were accurately dated and timed, with the full signature of the nurse making the entry. Nursing assessments were completed satisfactorily. However, nursing evaluations were not always completed and there was a need for greater correlation between the nursing assessment, nursing plan and nursing evaluations. Ideally, the nursing records should reflect the involvement of patients in planning and making choices and decisions about their own care and treatment and should contain entries about patients' wishes, preferences and suggestions and, similarly, evaluations of the nursing care plans should include the patients' views about progress. Provision was made within the nursing documentation for the recording of the patient's primary nurse, but this was not recorded in the nursing records examined. While the overall standard of the nursing records was satisfactory, it was suggested that the current records be audited to identify areas for improvement and staff development.

A number of patients at the Department of Psychiatry were interviewed to ascertain their views on the services provided. Patients were generally satisfied with the admission process and with the courtesy and helpfulness of staff. All were aware of the names of their treating consultant psychiatrists and had adequate access to them while hospitalised. All patients had been shown around the ward on admission, or within a reasonable time thereafter. Patients reported that they were not allowed wear their own clothes following admission and no explanation as to why they were not allowed to wear them was given. While there was a comprehensive information booklet for patients, with pertinent information relating to a patient's stay in hospital, one patient interviewed reported that he had not seen the information booklet and one had not been offered to him. Patients reported that they were not made aware of or given access to information about their rights under the Mental Treatment Act, 1945 or the local hospital complaints procedure. Patients were generally satisfied with all aspects of privacy and dignity in relation to their care while hospitalised. All were satisfied with the sleeping arrangements and with the sanitary arrangements. Patients reported that there was adequate respect given for their privacy when being given information about treatment or advice by members of the professional team. While patients were satisfied with the heating, cleanliness, décor and catering facilities, those interviewed, especially those in the acute area, Department of Psychiatry, Wateford Regional Hospital, expressed a desire for access to fresh air for short periods during the day.

All the patients interviewed expressed general satisfaction with the medical care provided and all reported that they had been given reasonable information about the nature of their medical condition and that medical staff had reasonable discussions with them relating to prescribed medicines and their effects and possible side effects. Patients reported that they had adequate contact with nursing staff while hospitalised and that nurses took time to listen to their anxieties and queries about their care and treatment. One patient was aware

that he had a nursing care plan and that there was a nurse with primary responsibility for his care, but reported that the nurses changed frequently. Patients’ views were highlighted to enable local multi-disciplinary teams review services and practices with a view to ensuring that choices and high-quality services and information were available to patients and their families.

RECOMMENDATIONS

It is recommended that:—

1. The former RMS’s residence be acquired and adapted for use as a high-support residence to allow St Enda’s to close.
2. Care of the older persons in St Otteran’s not requiring specialist care from the later-life psychiatry service, be transferred to the regional services for older persons.
3. Additional community residence accommodation be provided.
4. Further day hospital accommodation be provided, particularly in Waterford city.
5. The sectors be strengthened by the provision of headquarter premises in each, accommodating multi-disciplinary clinical staff.
6. Dedicated accommodation be provided in the acute psychiatric unit of Waterford Regional Hospital for the later-life psychiatry service.

WEXFORD MENTAL HEALTH SERVICE — 2002 INSPECTION

INSPECTED ON 19 AND 20 JUNE, 2002

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 104,371 was divided into four sectors as follows:

Sector	Population
Wexford	32,085
Enniscorthy	25,265
Gorey	24,008
New Ross	23,013

IN-PATIENT CARE

In-patient care was provided at St Senan’s Hospital, which had 174 beds in four male, four female and three integrated units.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	—	8	10	3	1	22	15.1
3 to 12 Months	—	—	4	3	2	2	11	7.5
1 to 5 Years	—	—	7	4	10	16	37	25.3
Over 5 Years	—	—	14	26	14	22	76	52.1
All Lengths of Stay	—	—	33	43	29	41	146	100
% of Total	—	—	22.6	29.45	19.86	28.08	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
7	39	14	21	3	6
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
1	9	1	39	6	146

Status of In-Patients on the date of inspection 2002

Status	Male	Female	Total
Voluntary	67	57	124
Temporary	6	3	9
P.U.M.	10	9	19
Ward of Court	2	—	2
Total	85	69	154

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
585	5.6	145	24.8	90.5	9.5	566	9

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of Persons Attending
Day Hospitals	1	Not specified	660
Day Centres	2	76	109
Out-patient clinics	4	297*	Not specified

*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
6	24	6	35	2	23

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
12	18	170	70	4

COST

The cost of the Wexford Mental Health Service was €13.29 million in 2001.

GENERAL COMMENTS

There had been major difficulties in the inter-personal and inter-professional relationships in this service in recent years which, in the opinion of the Inspectorate, have had a damaging effect on creating new initiatives, in developing and extending existing provision and in progressing matters for the benefit of the service in an orderly and planned fashion. These difficulties were of such depth and intensity that, in the Inspectorate’s opinion, they needed immediate resolution.

Since the inspection of 2001, there had been some new departures and advances. A premises had been secured for day-centre activity on the campus of St John’s Hospital, Ennis-corthy. Negotiations were proceeding with voluntary housing organisations, including the Mental Health Association, to provide a community residence for intellectually disabled persons currently in St Senan’s Hospital at Oylegate. Simultaneously, these intellectually disabled persons resident in St Senan’s were now participating in a programme of day care, which had been set up at St Aidan’s centre in Gorey. Currently, five female intellectually disabled persons from St Brendan’s Ward went out on a daily basis from St Senan’s to this day centre by being conveyed there and back by the day centre mini-bus. It was shortly hoped to extend the numbers attending and to include male patients from St Christopher’s Ward.

The sleeping arrangements in St Christopher’s had been substantially improved during the previous year. The introduction of structural changes within the fabric of the ward had created four-place sleeping areas instead of the large dormitory that previously existed. The specialised psychiatric service for older persons, consultant-led, was now concentrating on converting St Anne’s Ward into an acute assessment unit for that service. To that end, most of the former patients of the ward had been transferred to other locations within the hospital. Once the ward was empty, it would be the subject of redecoration and refurbishment before taking up its role with the later-life psychiatry service.

The Inspectorate had two major concerns about the Wexford service. The first related to the slow pace of community-based developments. Apart from the Wexford sector, no sector headquarters or day hospitals or community mental health centres existed in the

service and the supply of high- to medium-support community residential accommodation available was very limited. There was a crying need for the planning and putting in place of such community provision. The second concern was the totally unsatisfactory nature of acute in-patient accommodation for this service. Currently, there were two admission wards, St Clare's for males and St Brigid's for females. To say that neither was satisfactory was an understatement. The reasons why the Inspectorate was of that view are set out clearly in the body of this report. For this reason, and for the purpose of invigorating and enlivening and giving new impetus to this service, it was imperative that acute in-patient hospital accommodation be provided through the establishment of an acute psychiatric unit for the county at Wexford General Hospital, in line with national policy.

The physical difficulties of the two admission units were compounded by the lack of a rigorously implemented admission policy. The consequence of this was that beds in the two admission wards appeared to be oversubscribed on a regular basis. To provide additional admission beds, patients were transferred, mainly on a junior doctor's decision, to the pre-discharge unit or, sometimes, to St Gertrude's Ward. This upheaval was quite unacceptable from the point of view of quality patient care and, once again, exhibited the deficiencies or lack of co-ordinated and consensual planning approaches to problems in this service. A 'lodging out' procedure was commonplace and, in the month prior to this inspection, had occurred on no less than seventy-seven occasions.

The newly established psychiatric service for older persons suffered also from the admission difficulties, with no suitable acute admission assessment facility. Although a ward in St Senan's, St Anne's, had been refurbished for this purpose, this was an unsatisfactory stopgap arrangement. Obviously, the requirement here was for a small sub-unit within a general hospital unit. Similarly, this service lacked day hospital accommodation and, here again, efforts to plan for such provision on the campus of, or close to, Wexford General Hospital, should be in train.

There was, in theory, a consultant-led rehabilitation service in place. The Inspectorate was not convinced, however, that the theory reflected the reality in this particular instance and saw no evidence of any active rehabilitation inputs or of multi-disciplinary review of younger, long-stay patients with a view to their pre-community-placement assessment and preparation. The Inspectorate was told, however, that nurses in these wards did have regular meetings, but without a medical presence.

Many of the long-stay patients in St Senan's were older persons, with close on forty-five per cent being over sixty-five years, and required specialised care. The Inspectorate would urge that such patients be placed in a de-designated service for older persons, rather than in a psychiatric setting.

The Inspector's report of 2001 commented on the paucity and brevity of medical case note taking indicating a lack of review of longer-stay patients. Some improvement in the situation was noted on this inspection, although written consultant input was still lacking.

Case note documentation and recording practices generally were, in certain instances, of poor quality. It was not possible, in many cases, from case note documentation to understand the process leading to admission of individual patients and, in many instances, a programmed approach to their care did not appear in case notes. The case note structure and sequencing, of itself, needed improvement.

During the past year, an assessment of all intellectually disabled residents was carried out by psychological teams from the Brothers of Charity, Belmont Park Service in Waterford because, it was reported, the service's own psychologists were too busy with other duties to undertake this work. Although there was the equivalent of three psychologists in this service, there was no social worker and no occupational therapist.

Staff members did not, it was noticed, wear identification badges. The majority of wards in St Senan's were locked, unnecessarily so, in the Inspectorate's view.

Twenty-two patients were prescribed ECT at St Senan's Hospital in 2001. There was a dedicated ECT treatment suite on the second floor of the hospital. A named consultant psychiatrist was responsible for the ECT treatment and there was an induction process for all new doctors. The pre-ECT nursing checklist was completed satisfactorily and the consent form in use was satisfactory. The ECT nursing checklist should be reviewed to include a pre- and post-ECT nursing checklist.

Records of fire and health and safety committee meetings were examined as part of this inspection and were up-to-date. Health and safety statements were dated 1997 and all were under review at the time of this inspection. Site-specific health and safety statements were available for each ward area of St Senan's Hospital. All of this was very satisfactory. The management team met approximately every seven weeks, and minutes of meetings were kept. Management team meetings were attended by the regional manager, the director of nursing, the medical superintendent and the hospital manager.

Six patients were placed in seclusion in St Senan's in 2001 and there were thirty-nine episodes of seclusion during the year. The policy and procedure relating to seclusion was dated 1992 and required review and updating. Six patients were placed on one nurse to one patient special supervision and there were 621 episodes of special supervision involving duty spans of ten hours or more. Special nursing supervision was usually initiated and discontinued on the instructions of the patient's consultant psychiatrist. Specific, auditable criteria for levels of observation and supervision should be developed, including a review of the duration of observation of patients under special supervision undertaken by one staff member.

There were ten recorded accidents to patients and eleven recorded accidents to staff in St Senan's in 2001. Three of the patients' accidents were deemed serious. There were six recorded assaults on patients by other patients, four involving minor injuries. There were twenty-seven recorded assaults on staff at St Senan's in 2001, twenty-three involved minor injuries and one resulted in serious injury. The procedure for reporting accidents and incidents appeared satisfactory. There was one recorded complaint by a patient or relatives

to the local complaints manager in 2001 and five requests under the Freedom of Information Act.

Generally, staff appeared aware of the importance of approved policies and procedures and protocols in reducing the level of risk. The policy and procedure manual was dated 1992 and there appeared to be, from the on-site visit, a lack of clarity on what constituted a policy, procedure, protocol or guideline. There was no system in place, which ensured that documents were dated as per their implementation date, no formal consistent means of ratification, no formal implementation process, no compliance audit or assessment of effectiveness. Ideally, all of these policies should be reviewed and each policy, procedure and protocol should have a truly multi-disciplinary focus, be individually numbered, with the date of ratification and an appropriate review date. A system should be in place to ensure a computerised index of all policy documentation and revised and superseded policies should be removed from operation. Changes to policies, protocols and guidelines should be dated and signed and policies should be formally introduced to relevant staff, ensuring awareness and understanding of content. Staff should sign to say that they have read, understood and are able to comply with the policy content. There should be a regular review of policy validity, with an incorporation of an audit process to enable assessment of efficacy and compliance.

Guidance notes for staff on the management of illicit drug use or drug-related incidents, setting out action to be taken on suspicion of illicit drug use or supply, and policy for staff to search and confiscate illicit drugs, alcohol or dangerous weapons. The policy should also contain information on arrangements with local Gardaí relating to disposal of confiscated illicit drugs or dangerous articles.

The written policy for ordering, prescribing, storing and administration of medicines was dated 1997 and there was no appropriate review date. Written instructions on the use of prescription cards was required. Most prescriptions examined were either in block letters, and those that were scripted were not difficult to read, indicating a low risk factor of incorrect drug administration. Most, but not all, of the prescriptions were signed and dated individually. The discontinuation column had one signature and one date for each prescription, which was very satisfactory.

The Inspectorate very much welcomed the introduction of an information handbook for patients and relatives on admission, containing information on the care team, ward administration, smoking policy, visiting arrangements, patients' rights and other information pertinent to a patient's stay in hospital. The information leaflet for St Clare's Ward was more detailed than the one for St Brigid's Ward. It was recommended that a unitary information booklet be available for all patients in St Senan's Hospital, incorporating relevant information from the existing leaflets, with the addition of information for patients on in-patient hospital charges.

The service provider should consider addressing the provision of patient activities and facilities by ensuring that all patients were aware of opportunities on offer, both through publicly displayed information and individual discussions with patients as part of their

care plan. On a number of long-stay units, patients were observed sitting on lounges or in bedroom areas with little or no discernible focus of activity. All too often, the Inspectorate encountered bored patients whose only recreational activities were smoking and watching television.

All staff should wear identification badges to indicate their designation within the multi-disciplinary team. Records of multi-disciplinary team meetings were kept in ward areas. These were attended solely by nurses, rather than having a multi-disciplinary focus. A new nurse care planning system, using the Peplau model of nursing, had been introduced since the last visit of inspection. The nursing model, which was a conceptual framework for understanding the role and function of nursing and the delivery of nursing intervention, replaced an older model used extensively in the SEHB for the past ten years. This new model, which was very much in its infancy in the two admission units at the time of this inspection, was designed to enhance patient care and provide nurses with the means of defining the process of that care, which could be operationally acceptable and empirically validated. Nursing ward progress notes were recorded in most of the long-stay wards and in the pre-discharge unit. There was a need for intensive retraining of nursing staff to ensure that the new Peplau nursing model was extended to all patient care areas within St Senan's Hospital.

Biographical information and nursing assessment was appropriately recorded in the admission units, but there was a need for greater correlation between the nursing objective and plan and the nursing notes. Nursing records should reflect the involvement of patients in planning and making choices and decisions about their own care and treatment. Similarly, nursing evaluations should include patients' views about progress. All nursing notes examined in the admission unit confirmed that patients appeared to settle well into the ward at the end of their first day of hospitalisation. Entries were made as soon as possible after events to which they related and time of entry was appropriately recorded. The patient's name, date of birth and address were all accurately recorded in nursing notes. Abbreviations were used and the service had a recognised list of abbreviations.

Traditionally, nursing administration staff were based at St Senan's Hospital. With the development of sectorisation, multi-disciplinary teams, specialist services and the strategic aim of devolved management, this was an opportune time to further review the nursing management structures in this service. The system whereby ADNOS rotated on night duty every three months led to a lack of continuity in relation to supervision and service development. The role of the ADNOS within the Wexford mental health service should be reviewed, as the present system of deployment was less than satisfactory.

A number of patients in St Brigid's admission unit were interviewed to ascertain their views on the level of care provided. All patients reported that, within a reasonable time after admission, they were introduced to the professional team responsible for their care. While one patient was satisfied with the admission process and the courtesy and helpfulness of staff, two patients complained of the length of waiting time prior to admission. Patients were informed of the name of the consultant psychiatrist responsible for their care and all reported reasonable access to them while hospitalised. All patients reported

that they were shown around the ward on admission or within a reasonable time thereafter. One patient who was not allowed wear their own clothing post admission, reported that no explanation was given for this. All patients reported that they were offered an information booklet about the ward on admission and were made aware of their rights under the Mental Treatment Act, 1945 and the local complaints procedure. Patients were generally satisfied with all aspects of privacy and dignity in relation to their care and with the sleeping arrangements. Patients reported having adequate storage space for clothing and personal belongings, but there were no facilities available to wash personal clothing. Patients felt there was adequate respect for privacy when they were being given information about treatment or advice. However, one patient expressed discomfort at having to attend multi-disciplinary team meetings with approximately seven staff present. Two patients were satisfied with the services provided by their consultant and junior doctor, and one patient complained that ‘the consultants appeared to change too often’. Two patients reported that they had not been given reasonable information about the nature of their medical condition, including medication and treatment. Patients expressed general satisfaction with the overall cleanliness of the ward, bathroom and toilet facilities. They were satisfied with the overall décor and with the facilities for visitors. Patients interviewed were generally dissatisfied with the quality and quantity of food provided. All patients complained about the locking of the external ward doors, with comments such as ‘Locking of doors — terrible’, ‘Too much locking of doors’, ‘No access to fresh air’. One patient expressed dissatisfaction at the lodging-out arrangements, where she was shifted from ward to ward to facilitate new admissions. Two patients were aware that they had a nursing care plan. All patients felt that they had enough contact with nursing staff and that nurses spent an adequate amount of time talking and listening to patients.

RECOMMENDATIONS

It is recommended that:—

1. Immediate executive action be taken to deal with the situation of intense disharmony and disunity existing between senior staff members in the service because of the serious consequences that this has for service development and patient care.
2. The establishment of an acute psychiatric in-patient unit at Wexford General Hospital be proceeded with, with urgent dispatch.
3. A responsible and appropriately constituted planning group be set up to plan the future of the Wexford mental health service and, as part of that responsibility, with a commitment to putting in place day hospital, residential and other community-based services.

CHAPTER EIGHT

Southern Health Board

KERRY MENTAL HEALTH SERVICE — 2002 INSPECTION
INSPECTED ON 10 SEPTEMBER, 2002

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 126,130 was divided into five sectors as follows:

Sector	Population
Listowel	24,530
Tralee East/Dingle	25,929
Tralee West	25,369
Killarney	25,676
Killorglin/Kenmare/Cahirciveen	24,626

IN-PATIENT CARE

In-patient care was provided at St Finan’s Hospital, Killarney, which had 145 beds in five male and four female wards, and at the fifty-bed acute unit, Tralee General Hospital.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	1	20	15	9	7	52	27.1
3 to 12 Months	—	—	1	4	1	—	6	3.1
1 to 5 Years	—	—	6	10	6	3	25	13.0
Over 5 Years	—	—	3	37	40	29	109	56.8
All Lengths of Stay	—	1	30	66	56	39	192	100
% of Total	—	0.5	15.6	34.4	29.2	20.3	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
10	106	—	28	11	6
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
11	8	—	12	—	192

Status of In-Patients on the date of inspection 2002 — Department of Psychiatry, Tralee General Hospital

Status	Male	Female	Total
Voluntary	22	12	34
Temporary	9	4	13
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	31	16	47

Status of In-Patients on the date of inspection 2002 — St Finan’s Hospital

Status	Male	Female	Total
Voluntary	52	37	89
Temporary	10	7	17
P.U.M.	4	8	12
Ward of Court	7	3	10
Total	73	55	128

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
897	7.1	254	28.3	88.0	12.0	936	20

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of Persons Attending
Day Hospitals	3	59	242
Day Centres	5	97	143
Out-patient clinics	8	301*	1,569

*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
12	60	—	—	4	65

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
12.67	11.33	262.09	82.25	5.33

COST

The cost of the Kerry Mental Health Service was €14.73 million in 2001.

GENERAL COMMENTS

The putting in place of a fifth consultant-led team in general adult psychiatry was welcomed and, as a result, the catchment area of Kerry had been redrawn to provide five sectors. These now were: Listowel; Tralee West; Tralee East and Dingle; Killarney; Kenmare, Caherciveen and Killorglin.

The Inspectorate was happy to report that, since the 2001 inspection, there had been further initiatives and developments in this service. The new Caherina day hospital and sector headquarters in Tralee had opened and thought had been given as to the future use of the old building that formerly provided this service. The high-support residence in Listowel, which had not yet acquired a name for itself, opened in July 2002 and had fourteen places. In Caherciveen, a five-place local authority house had been acquired and now housed three residents. In addition, and still in Caherciveen, the local branch of the Kerry Mental Health Association had purchased, extended and refurbished a single-storey house in its own grounds, facing the District Hospital with its mental health complex of high-support residence, day centre and training workshop. Further initiatives put in place included enlargement of the residential Teach An Churaim, Rathmore and day provision in Rathmore through the commitment of the local voluntary group, the Rathmore Social Action Group. Work was due to begin shortly on the planning of a rehabilitation and training complex on the site adjacent to and currently occupied by the Ross and Mangerton group homes adjacent to St Finan's Hospital. Coolgrane Training Centre had transferred to the new purpose built facility adjacent to St Finan's Hospital in July 2001. Plans were being developed in conjunction with Kerry Mental Health Association to provide a purpose built High Support Community Residence at the rear of Ross and Mangerton Residences. This facility would replace the existing High Support Community Residence at Cherryfield.

It was heartening to learn that the Cherryfield complex in Killarney, whose continued use as a mental health facility was in jeopardy last year, was now to continue in psychiatric usage and it was planned to move the industrial and rehabilitation initiative from Cherryfield to a location projected on the Ross and Mangerton site just referred to. Once this had occurred, those patients currently in St Denis's ward (now moved to St Peter's ward) and in St Bernadette's ward (shortly to move down to the former St Martin's ward) in St Finan's Hospital, would move to the vacated space in Cherryfield. A project to construct an additional building in the grounds of Killarden House in Tralee was approaching the planning stage. The purpose of this endeavour was to separate the day centre and hostel functions of the current building at Killarden by providing each with separate services in its own building, rather than the combined function of the existing house. The current day centre facility at Fertha View in Caherciveen, with consultant inputs once a fortnight, was to become more active, with more frequent team presence, in an effort to move this activity towards a day hospital function. A premises had been identified and a day centre was shortly to be established at Kenmare. It was also proposed to move the current day centre activity in Dingle to a more satisfactory location in that town. The possibility of

acquiring the former guesthouse in Killarney, Park Lodge, had now receded. The Kerry service was committed to bringing an outreach philosophy and practice to care delivery and, although the implementation of this commitment was still in its infancy, it was exemplified by the putting in place of a primary care nurse liaison service in the Listowel sector.

The psychiatric unit in Tralee General Hospital had now acquired the legal status of a district mental hospital and so would be able to admit persons of unsound mind reception category who formerly were taken to St Finan's Hospital, Killarney, under Garda escort. This undesirable practice would now cease. With the projected transfer of patients from the remaining two locked wards in St Finan's, St Peter's and St Bernadette's, to Cherryfield, these wards would close and, therefore, the practice of transferring difficult to manage patients from the Tralee unit to St Finan's would cease. These changes would require a safe room as part of a high-observation facility to be put in place in the unit at Tralee. Planning for this was shortly to begin and would take place in conjunction with the contemporaneous provision of an adequate occupational therapy department for the unit. As a specialised later-life psychiatry service was shortly to come into operation, the question of the necessity for and location of acute assessment beds for this service, as well as a day hospital, would shortly be under discussion.

In Killarney, it was encouraging to be reassured about the commitment to closing the two locked wards, St Denis's for males and St Bernadette's for females, and moving the patients from these wards to accommodation at Cherryfield, Killarney. While awaiting this outcome, it was decided to move both these wards to upgraded former wards that had now become empty on the lower floors. That had already happened in relation to St Denis's, which had moved to the former St Peter's. St Peter's had been repainted, decorated and some upgraded furniture had been provided. The result was a reduction in the number of patients in the ward and the general behaviour of residents had greatly improved. However, the structural unsuitability of St Finan's Hospital for modern psychiatric care, despite decoration and refurnishing, was evident even in this initiative. St Bernadette's ward was still in its original position, but the move to the redecorated downstairs ward was shortly to take place. The overall unsuitability of the day and dormitory spaces and the design characteristics of the nineteenth-century asylum building were evident in the remaining wards of St Finan's. Thus, the remaining four wards in St Finan's were drab and dreary to an unacceptable degree on the male side, but less so on the female side where attempts to domesticate and 'civilise' the interiors had been undertaken, with some measure of success. However, these wards essentially provided shelter and meals for populations of older persons, as did the more modern, free-standing O'Connor Unit, where the accommodation was of a much higher order than in the four St Finan's wards.

The exodus of St Denis's and St Bernadette's patients would emphasise the age of the remaining patients, of whom somewhere between sixty-five and seventy per cent would be aged over sixty-five years. These wards were, for the most part, providing for physical rather than psychiatric needs, which had evaporated for the most part, and one male and one female ward functioned as 'infirmaries', catering for the sick and, in some cases dying, patients. It was the Inspectorate's view that the care delivered and functions provided in these wards more properly belonged to an integrated and comprehensive service for older

persons. It was speculated that, if such were available, benefits would accrue, particularly to the elderly who formed a not insubstantial number of these patients. The projected mortality, on a life table basis, of these residents would lead to the vacation of the old building in St Finan's, and its closure for psychiatric purposes. This matter had been addressed by the commissioning of a consultant's report and a number of alternatives had been proposed. Among them was the retention of the building and its adaptation for further health purposes or, alternatively, its sale, with the retention of some of the grounds and the possibility of building a continuing care unit for the later-life psychiatry service on part of the retained land.

As the clinicians and administrators acknowledged, there was a need for sector headquarters and day hospital premises in this service. The existing and proposed provisions in Tralee could, with imagination and further enhancement, serve both Tralee sectors, but something needed to be done in this regard in Listowel and one wondered whether the existing day centre at Senan House might not be adapted for this purpose by bringing in the currently unused top storey and the placing of the day centre operation in alternative premises. In putting forward this suggestion to the service, the Inspectorate acknowledged that the Senan House premises did have some shortcomings as a day hospital/sector headquarters premises. The current Killarney day hospital was too small and, in any case, did not function as an acute day hospital. Therefore, alternative premises, serving also as a sector headquarters, were required in that sector. The solution to the problem in the fifth and final sector, in which the main towns were Killorglin and Caherciveen, posed challenges for innovation, given the geographic characteristics of the sector.

The psychiatric unit at Tralee General Hospital was working satisfactorily, but there did appear to be a problem relating to inadequate day space, an inadequate safe room and inadequate space for occupational, recreational and diversional therapy. In addition, some patients were presenting at the unit for assessment, while others were presenting at the A & E Department. It was the Inspectorate's opinion that all assessments should be filtered through the A & E Department, where the patients should first be assessed physically and then psychiatrically. Assessment should, as far as possible, be carried out in a community setting. Alcohol dependent patients were still admitted to the unit for detoxification. It was the view of the Inspectorate that detoxification should be a medical procedure carried out by primary care providers or, in acute cases, in beds on medical wards. A written policy was required relating to the use of the personal safety alarms provided for staff. It was noted that some staff were not wearing their personal safety alarms; this matter required attention. One hundred and eight patients were admitted involuntarily to the Kerry service in 2001. Six of those patients had their involuntary status changed to voluntary during the course of their hospitalisation. Three patients admitted as voluntary were regraded involuntary post-admission. Sixteen patients in the service had their temporary reception and detention orders extended during the year. Fourteen patients were transferred from the Valentia and Reask wards to other medical wards at Tralee General Hospital during 2001. Twenty-six patients took their own discharge from the service against medical advice in 2001. Appropriate procedures were in place for follow-up.

There were nineteen deaths in St Finan's Hospital and one death at the Department of Psychiatry in Tralee General Hospital in 2001. Eight patients became new long-stay, having been hospitalised for over one year continuously and two of those patients were aged sixty-five years or older. There were three complaints made by patients or patients' relatives to the local complaints manager at St Finan's Hospital in 2001 and seventeen requests were made under the Freedom of Information Act. All appeared to have been dealt with satisfactorily. Information relating to complaints and requests under the Freedom of Information Act at Tralee General Hospital was not available. Management at this unit should closely monitor the handling and outcome of all complaints, both to ensure minimum delay and note any quality implications arising from a complaint. Statistical data relating to complaints and outcomes should be kept.

Twelve patients were placed in seclusion at Tralee General Hospital and there were twenty-eight episodes of seclusion in 2001. Nine patients were placed in seclusion at St Finan's Hospital, with thirty-three episodes during the year. The safe room at Tralee General Hospital was far from ideal; the room itself was not safe and more structurally appropriate facilities were required. There was no privacy in the existing safe room, which was just off the main corridor adjacent to the nurses' station. There were blind spots in the room and dangerous fittings. An appropriate seclusion register was maintained. Documentation in relation to fifteen-minute observations of patients in seclusion was kept in the patients' clinical notes. The policy and procedure relating to seclusion and its use required review and updating.

Twenty-five patients were prescribed ECT at Tralee General Hospital in 2001. The facilities for ECT were satisfactory. There was a dedicated ECT suite, consisting of treatment, waiting and recovery areas. A named consultant was responsible for the ECT clinic and there was an appropriate induction process for new doctors. Special nursing supervision, or close observation, was a significant event in acute in-patient settings. Statistical records of its use should be kept. A minimum dataset should include: reasons for observation, specific levels of observation/supervision, length of time observed, and any untoward incidents. A review should be undertaken of the duration of one-nurse-to-one-patient special observation undertaken by one staff member and records should be kept of the patient's and nurse's views of the process. All of these should be reviewed by the consultant psychiatrist and the clinical nurse manager. Records relating to the number of patients placed on one-to-one special nursing supervision at Tralee General Hospital should be kept.

As mentioned in previous reports, a recording system should be in place at Tralee General Hospital to record accidents and assaults to patients and staff and any untoward incidents. There should also be regular scrutiny of the statistics by unit managers to provide analysis by time of day, geographical location, cause of accident, incident or assault, and nature of injury. Statistical data relating to accidents to staff and patients at St Finan's Hospital were appropriately recorded. There were fifty-nine accidents to patients, nine involving mild injury such as scratches or bruising, and five accidents to staff, none of which were deemed serious. There were eighteen assaults on patients by other patients, three resulting in mild injury, and sixteen assaults on staff, five resulting in mild injury, scratch or bruising.

A system should be in place to ensure patients are adequately informed of the complaints and dissatisfaction procedure and of their rights under the Mental Treatment Act, 1945, and amending legislation. Experience showed that where patients did not understand their legal position and rights, there was evidence of poor practice in providing communication at an appropriate level and checking that this had been understood. It was understood that services were sensitive to the capacity of each individual patient to understand his or her rights during the course of an acute illness. Nevertheless, these should be explained as far as possible in a way the patient could understand. The giving of information on rights to detained patients should be adequately recorded in the patients' case notes, with 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.

At the time of the last inspection of this service in July 2001, the service managers were updating operational policies and procedures in accordance with service needs. The formulation of policies, protocols and standards should be developed on a multi-disciplinary basis between all pertinent groups, but particularly between medical and nursing staff.

The quality and content of the nursing documentation was varied. Not all sections of the nursing care plan were completed at St Finan's Hospital and no record was made of the reason for this. Basic nursing notes were recorded in most wards at St Finan's Hospital. Nursing care plans were recorded as part of the integrated file at Tralee General Hospital. Nursing records examined confirmed that patients appeared to settle well into the ward at the end of their first day of hospitalisation. Records identified problems and actions taken by staff to rectify them. All entries in the nursing records were accurately dated. Time of entry was not recorded. It was suggested that all nursing records be audited to establish standard of record and identify areas for improvement and staff development. The patient's primary nurse should be entered in the nursing record and the patient's name, age and hospital number should be recorded on each continuation page. It was noted that some evaluations of nursing care plans included patients' views about progress and this was satisfactory. Ideally, the nursing record should reflect the involvement of patients in planning and making choices and decisions about their own care and treatment.

Generally, each newly admitted patient had a full medical evaluation, including comprehensive admission notes, mental state examination, physical examination and clear and immediate management plan appropriately recorded. However, one patient admitted a few days prior to this inspection had no record of a physical examination recorded in the medical notes. While there was provision for the recording of the patient's name on each continuation page, this was not always recorded on the notes examined. A number of wards at St Finan's Hospital had no safety statements, while a number had safety statements that required review and updating. Safety statements should be available in each local area and hazard-control sheets should be available indicating periodic safety audits. All staff should be encouraged to wear the safety alarm in all areas where they were provided.

Three patients, randomly selected, were interviewed in the psychiatric unit of Tralee General Hospital to assess their opinion of the services provided. All were quite pleased with

the admitting procedures and were immediately acquainted with their primary nurses and consultant psychiatrists. The patients' ages ranged from thirty to sixty years and all were of voluntary status. Each saw their consultant psychiatrist between three and four times per week, and all were very pleased with their interaction with the nursing staff and found them very helpful. One had heard of a nursing care plan, while the other two had not. All were very pleased with the dignity and respect afforded them and at no time did they feel their privacy was invaded. All were pleased with the information given to them about their psychological problems and prescribed medications were fully explained to them. One patient requested and received written information on medications. When asked how the services could be improved, an interesting spectrum of responses was given. One could find no fault at all with the services and felt they did not need improving. The second patient, while admitting there were ample activities to participate in, was not particularly interested in them and felt patients should be allowed home for a short time each week and that this would expedite recovery. The third patient felt that boredom was the main area of concern; there should be far more activities during the day, particularly at weekends. Another area of concern mentioned by one patient and implied by another was the ambience of the day room. This, they felt, totally lacked character and was anything but homely and was certainly non-therapeutic. They particularly disliked the furniture and the general layout of the area.

It was particularly interesting to hear the comments of one patient as to the treatment administered and the 'marvellous' outcome. This patient had been suffering from depression on and off for years, but invariably it responded to medications. However, over the last few years the depression became drug resistant and electro-convulsive therapy was prescribed. The patient had had four treatments and felt so pleased with the outcome that he was hoping that more would be given. This, indeed, was a very positive patient opinion on the efficacy of this therapy.

RECOMMENDATIONS

Because the Kerry service has made significant strides in recent years and has a clearly delineated vision of where to go in the future, the Inspectorate will restrict itself to two recommendations.

It is recommended that:—

1. The commitment to enhancing community mental health centres/day hospitals/sector headquarters in which an active, assertive outreach programme can be mounted should be pursued.
2. The four wards catering for older persons in St Finan's Hospital and the O'Connor Unit be de-designated and integrated with the elderly service for the county.

NORTH CORK MENTAL HEALTH SERVICE — 2002 INSPECTION

INSPECTED ON 14 AUGUST, 2002

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 71,234 was divided into three sectors as follows:

Sector	Population
Fermoy	23,878
Mallow	25,405
Kanturk	21,951

IN-PATIENT CARE

In-patient care was provided at St Stephen’s Hospital, Glanmire, which had 210 beds in nine integrated wards.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	—	18	12	1	2	33	15.79
3 to 12 Months	—	—	5	7	1	4	17	8.13
1 to 5 Years	—	—	7	5	8	7	27	12.92
Over 5 Years	—	—	5	42	49	36	132	63.16
All Lengths of Stay	—	—	35	66	59	49	209	100
% of Total	—	—	16.75	31.58	28.23	23.44	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
10	114	—	44	7	3
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
6	5	1	15	4	209

Status of In-Patients on the date of inspection 2002

Status	Male	Female	Total
Voluntary	105	61	166
Temporary	6	5	11
P.U.M.	—	—	—
Ward of Court	4	5	9
Total	115	71	186

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
349	4.9	88	25.2	93.1	6.9	342	15

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of Persons Attending
Day Hospitals	1	25	59
Day Centres	3	44	92
Out-patient clinics	4	130*	710

*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
3	12	—	—	1	14

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
9.5	17.86	185.50	73.76	7.83

COST

The cost of the North Cork Mental Health Service was €17.9 million in 2001.

GENERAL COMMENTS

There had been some community developments or proposed developments in this catchment area since the inspection of 2001. A house had been purchased for group home purposes in Mallow and it was proposed to transfer some of the more able and less dependent patients from the Solas Nua supervised community residence in Mallow to this new acquisition. The patients so moved would be able to continue participation in the Mallow day centre. The places vacated in Solas Nua would be filled by patients from St Stephen’s. In Kanturk it was proposed to replicate the Solas Nua high-support facility by the purchase of two adjoining strips of land, one in private ownership and the other owned by the Department of Defence. It was also proposed to set up a new day centre to replace the existing Duhallow centre. Finally, in Fermoy, it was hoped to provide a combined high-support facility on the lines of Solas Nua in the grounds of St Patrick’s Hospital, with a separate day centre under the same roof. On the human resources side, there had been some augmentation of non-medical, non-nursing professionals, so that there were now three psychologists, the equivalent of two-and-a-half occupational therapists, and one social worker in the service. Additionally, in outward deployment and reinforcement of

community nursing personnel, additional skilled nurses augmented the existing community nurse arrangement in the sectors. However, there were no community mental health centres/sector headquarters/day hospitals in any of the three sectors; there was an ambition, set out in planning documents, to remedy this deficit. In 2000 a Cork city sector was transferred from North Cork catchment area to that of North Lee but our understanding was that patients from this sector continued to be admitted to St Stephens rather than, as should be the case to the Psychiatric Unit at the Mercy Hospital.

The bulk of patient care and staff deployment in this service revolved around St Stephen's Hospital, where currently there were approximately two hundred patients, of whom over half were aged sixty-five years or over, and one quarter aged seventy-five or over. Apart from the acute component and the specialised Alzheimer's unit, St Stephen's clientele comprised older persons and younger long-stay patients. A majority of both groups had been transferred from Our Lady's Hospital on its closure. The last of these patients transferred quite recently on the closing of St Kevin's, the last remaining component of the former Our Lady's Hospital. The older patients constituted a group requiring services for older people and the younger group an active rehabilitation service, neither of which existed in the service. Many of the patients exhibited behavioural abnormalities now rarely encountered elsewhere, the result of their long years of institutionalisation and therapeutic neglect in Our Lady's Hospital. These patients came from all four Cork catchment areas and were not the subject of active rehabilitation by a specialised multi-disciplinary team.

As well as this long-stay component, there was a constant inflow of inappropriate referrals, directed from sources other than those of the North Cork catchment area, into St Stephen's and there appeared to be a perception in some quarters that St Stephen's should cater for problems for which their own catchment areas did not have an appropriate resource or were not actively seeking it.

The clinical director of the North Cork service was also the clinical director of the acute intensive care component of the Carraig Mór unit, based in the former St Anne's admission unit at Shanakiel. As the majority of patients being admitted to the unit came from the South Lee catchment area, as well as some from the other two catchment areas of North Lee and West Cork, the Inspectorate felt this be a totally illogical arrangement and would recommend the appointment of a consultant specialising in intensive care to manage the intensive care component of Carraig Mór, with other related duties, such as providing specialised forensic services to the Cork prisons and that the upper floor of Carraig Mór become the responsibility of a specialised multi-disciplinary rehabilitation team. The notion apparently current in some quarters that St Stephens should provide "continuing care" for all four catchment areas without any specialised rehabilitation input was, the Inspectorate felt, untenable. The Cork services required, at the very least two, but preferably three, rehabilitation teams for rehabilitation of patients with enduring illness at Carraig Mór, in St Stephen's and in the community in a co-ordinated endeavour with the relevant catchment area teams. This appropriate and correct approach would represent a moving away from the comfortable position that St Stephen's should be the endpoint of clinical ambition for this group rather than community resettlement.

The lack of specialised input to the problems of the older and long-stay patients of St Stephen's and the admission of patients by professionals not of the catchment area team, together with the highly institutionalised and unsatisfactory nature of St Stephen's accommodation for modern purposes and the relative lack of community-based facilities, would lead the Inspectorate to suggest that even if former patients of Our Lady's had been transferred to undoubtedly better accommodation in St Stephen's, much of the culture and historic mores of that hospital persisted in the new location.

There were two acute admission units in St Stephen's, identical in plan and both unsuited to modern acute psychiatric care. The urgency of establishing an acute unit for the catchment area in Mallow General Hospital was overwhelming. The Inspectorate was somewhat disconcerted to be told that the attention of the management was currently centred on providing community-based facilities and that Mallow 'could wait for a few more years'. It is difficult to see why both matters could not be progressed simultaneously and immediately. In the meantime, the Inspectorate saw no reason why two admission units were necessary for the catchment area population of somewhat over 70,000. The Inspectorate would recommend that one admission unit should suffice and the other should be closed. Likewise, the Inspectorate believed that Unit 2, where high-quality care was delivered to older persons, should be de-designated.

The Inspectorate has already commented on the lack of specialised services in later-life psychiatry in this catchment area and notes that the same deficit existed in the adjoining North Lee area. It was felt that, at the very least, a shared service between these two catchment areas should be put in place.

There were eight complaints made by patients or relatives to the local complaints manager, and eighteen requests under the Freedom of Information Act in 2001. All appeared to have been dealt with satisfactorily. There was one research project undertaken in St Stephen's Hospital governed by the Clinical Trials Act 1987-1990. Appropriate procedures, as set out in this Act, were followed. Fifty-seven patients were placed on one-nurse-to-one-patient special nursing supervision and there were 577 duty spans of special nursing supervision involving duty hours of ten hours or more. Specific, auditable criteria for levels of observation and supervision should be developed, including identification of the skills required to ensure competency. The present policy and procedure relating to special observation should be reviewed and updated. Seclusion was not used in this service.

There were twenty-two temporary admissions to St Stephen's Hospital in 2001, seventeen male and five female. Eleven patients admitted involuntarily were regraded to voluntary status during the course of their hospitalisation. Eight patients admitted as voluntary patients were regraded to involuntary status during the course of their hospitalisation. There were twelve extensions of involuntary admission orders in 2001. Three persons admitted were aged sixteen years or under. Of the 342 discharges from the service in 2001, twenty-one patients took their own discharge against medical advice. Appropriate procedures were in place to follow up these patients if deemed clinically appropriate. There were fifteen deaths in St Stephen's in 2001. There was one death apparently by suicide in the hospital and the outcome of the inquest was awaited.

There were 174 accidents to patients and twelve accidents to staff in 2001. Four of the accidents to patients and one accident to staff were deemed serious. There were thirty-six assaults on patients by other patients and twenty-two assaults on staff. Two of the assaults on patients and four of the assaults on staff were deemed serious.

Fifteen patients were prescribed ECT treatment in 2001. The consent form for ECT was satisfactory. There was a pre- and post-ECT nursing checklist which was completed satisfactorily. The facilities for ECT were not ideal as there was no separate waiting room or recovery room. A named consultant psychiatrist was responsible for ECT. There was an appropriate induction process for new doctors.

The medical preparations policy and procedure required review and updating in the light of the changeover to a new prescription and recording system. The new drug prescription and administration record had provision for recording drug sensitivities or allergies and special precautions, so that information was rapidly available to staff. There was a need to change over to the new system as rapidly as possible. Prescriptions were signed and dated individually. While there was provision for the signature and date for each drug discontinued, this was not always completed on some cards inspected. There was an increased risk factor of incorrect drug administration in some of the long-stay wards where discontinued prescriptions were greater in number than current prescriptions.

A revised information booklet for patients and relatives, containing pertinent information relating to a patient's admission, hospital stay, and discharge, had been introduced and contained information on the local complaints procedure, rights of hospitalised patients and information on hospital charges.

The importance and value of policies, procedures and similar documentation had been recognised in this service. Generally, staff appeared aware of the importance of improved policies, procedures and protocols in reducing the level of risk. All policies and procedures should be reviewed and revised and superseded policies removed from operation. Efforts should be made to ensure clarity on what constitutes a policy, procedure, protocol or guideline. Ideally, each policy, procedure and protocol should have a multi-disciplinary focus where appropriate, be headed with either a unit or hospital title, be individually numbered for ease of reference and filing, and record the date of ratification and by whom, with an appropriate 'review by date' and 'audit by date', and detail responsibilities for these. All new policies, guidelines, protocols and procedures should be formally introduced to relevant staff, ensuring awareness and understanding of content. Relevant training and education should be given to staff when the policy, procedure or guideline contents affected current practice. When completed, staff should sign to say they have read, understood and intend to and are able to comply with the policy content. A system of regular review of policy validity should also be in place.

The nursing records consisted of a nursing care plan comprising historical and personal data, assessment details, nursing plan and nursing notes. All sections were generally well completed, although the quality of content was variable. All entries were signed and dated. Time of entry should be recorded, using the twenty-four-hour clock. Some assessments

carried out by student nurses were not counter-signed by staff nurses. Records examined confirmed that patients appeared to settle well into their ward at the end of their first day of hospitalisation. There was a need to audit the nursing records to assess standard of record and identify areas for improvement and staff development.

Three patients were randomly selected for interview to assess their opinions of the psychiatric services provided. All the patients were very pleased with the admitting procedures and were duly introduced to their therapeutic teams. They were quite satisfied with the frequency of their consultations with their consultant psychiatrist, which averaged to three per week. Two of the patients were voluntary and one was of temporary status. This latter patient was not allowed to wear their own clothing on admission and said this was to prevent absconding or harming oneself. The patient was allowed wear their own clothing within a matter of days and was currently in hospital for some four weeks. Two of the patients were not aware of their rights under the mental treatment legislation and none was aware of any complaints procedure being in situ.

While occupational therapy and diversionary activities were provided, two of the three patients had no interest in these, preferring to go for walks instead, while the third appreciated occupational therapy and other such therapies. All were satisfied with the dignity and privacy afforded them. All agreed they could have a bath or shower when requested. As regard laundry facilities, one patient complained that his own personal clothing was continually being misplaced in the laundry and was genuinely annoyed with this. No patient had any complaint with the food, general hygiene or décor of the unit, bathroom and toilet facilities, but one patient complained strongly about the unit being insufficiently heated and maintained this was due to the old metal windows needing immediate replacement. This was obvious to the Inspectorate also. All patients were pleased with the attention they received from the medical and nursing staff, but one complained that the injections received made him too drowsy. One patient had had access to a social worker and was very gratified with these inputs. As to their suggestions for improvements in the service, they ranged from replacing the old metal windows and thus improving the heating of the unit, to requesting that doctors not make a patient so drowsy with injections. All felt that the members of the multi-disciplinary team were very helpful.

RECOMMENDATIONS

It is recommended that:—

1. Community facilities in all three North Cork sectors be rapidly extended.
2. An acute psychiatric unit in Mallow General Hospital be provided and, in the interim, one of the two existing admission units in St Stephen's Hospital be closed.
3. At least two multidisciplinary specialist rehabilitation teams be established for the rehabilitation of patients in St Stephen's, in the communities of the four catchment areas and in Carraig Mór.
4. Access to the St Stephen's beds be restricted to the North Cork teams and to the specialised rehabilitation teams.

5. A specialised later-life psychiatry service, if necessary shared between North Cork and North Lee services, be established.

NORTH LEE MENTAL HEALTH SERVICE — 2002 INSPECTION

INSPECTED ON 13 AUGUST, 2002

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 145,233 was divided into five sectors as follows:

Sector	Population
City North West	30,732
City North East	26,535
Cobh/Glenville	30,217
Macroom/Blarney	29,813
Midleton/Youghal	27,936

IN-PATIENT CARE

In-patient care was provided at St Michael’s fifty-bed acute unit at the Mercy Hospital and at Carraig Mór.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	1	23	23	7	—	54	45.4
3 to 12 Months	—	—	2	1	1	—	4	3.4
1 to 5 Years	—	—	7	6	—	—	13	10.9
Over 5 Years	—	—	6	23	19	—	48	40.3
All Lengths of Stay	—	1	38	53	27	—	119	100
% of Total	—	0.8	31.9	44.5	22.7	—	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	35	1	55	8	2
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
7	3	3	3	2	119

Status of In-Patients on the date of inspection 2002 — St Michael’s Unit

Status	Male	Female	Total
Voluntary	23	17	40
Temporary	2	7	9
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	25	24	49

Status of In-Patients on the date of inspection 2002 — Carraig Mór

Status	Male	Female	Total
Voluntary	14	12	26
Temporary	11	4	15
P.U.M.	—	—	—
Ward of Court	1	—	1
Total	26	16	42

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
1,171	8.1	382	32.6	86	14	1,141	4

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of Persons Attending
Day Hospitals	2	40	149
Day Centres	2	30	70
Out-patient clinics	6	450*	Not specified

*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
3	13	—	—	3	47

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
26	12	179.06	43.1	8

COST

The cost of the North Lee Mental Health Service was €14.7 million in 2001.

GENERAL COMMENTS

This service was now divided into five sectors. It was quite an ambitious aspiration to have sector headquarters, day hospital facilities and community mental health centres in all five sectors — and it had not happened. There had been partial developments of this nature in two of the sectors, at Middleton and at Macroom, while the former day hospital operation in the orthopaedic hospital was being reviewed. However, the multi-disciplinary staffing of the sectors had improved greatly, with an influx of psychologists, social workers and occupational therapists. The closure of the two wards in the St Kevin’s building and the relocation of patients from there to the extensively refurbished former admission unit at St Anne’s, Shanakiel now called Carraig Mór was very much welcomed by the Inspectorate. There was a dearth of community residential accommodation, which hindered an appropriate rehabilitation endeavour. In fact, this service needed a specialised rehabilitation team, in common with or shared with the other two major Cork catchment area services of North Cork, and South Lee. Such a team was all the more desirable given the continuing deficits of those long-term patients occupying the top floor of the Carraig Mór unit. It would be necessary to acquire further community-based residential accommodation for the catchment area. There was a perceived need for a specialised later-life psychiatry service exclusive to this catchment area.

St Michael’s unit at the Mercy Hospital was functioning reasonably well and was an improvement on what was provided formerly, in St Anne’s, for admission purposes in the catchment area. There was, in the Inspectorate’s view, an over-emphasis on security, with uniformed security personnel on guard at the entrance to the unit, even if this entrance served both the psychiatric unit on the first floor and the newly established facility for the general elderly on the ground floor. Even though access on the ground floor did have secure control, it limited the freedom of patients and, in particular, denied them ready access to the open air. However, it was planned to provide a roof terrace with external access in the near future.

Because beds were in short supply in the unit, recourse was sometimes had, the Inspectorate was told, to transferring people to Carraig Mór, a procedure which the Inspectorate could not condone. In part, this may have been the consequence of inadequate community-based alternatives to hospitalisation and to inadequate triage or filtering mechanisms, so that patients who were referred for assessment or who were self-referred came directly to the unit without passing through A & E and were assessed in the unit itself by NCHDs, the NCHD of the sector during daytime hours and the NCHD on call thereafter. The Inspectorate had the impression that NCHD consultation with the consultant, either of the sector or the consultant on call, did not take place as a routine, and this may have been an aggravating factor in inappropriate admission and bed usage.

Case note documentation was of moderate quality only, and only partially informative in relation to paths to admission, reason for admission, and why alternatives to hospitalisation were considered inappropriate in each case. There was no evidence that patients

participated in care planning or that there was a care programme approach to their treatment, or that such matters were discussed with them. In fact, case note documentation on intake care programming and planning was rudimentary. Diagnostic formulations were of moderate quality and ICD numerical codes were not used. The Inspectorate was not satisfied that formal, weekly, multi-disciplinary team meetings took place on a regular basis on the part of each team. It appeared that all temporary patient reception orders were made by consultants and, in the event that a patient was transferred to Carraig Mór, that this was a consultant-made decision. Nursing staff did not wear identification badges and, although the Inspectorate was told that a primary nursing care scheme was in operation, subsequent interviews with patients did not confirm this. While nursing numbers were quite high, and certainly adequate for unit staffing, the Inspectorate was not convinced that there was sufficient nurse-patient interaction of a supportive therapeutic nature.

The thirty-two-place residential unit at Midleton functioned as a large-scale, high-support residence and was still registered as an approved premises despite the Inspectorate's repeated recommendations that it be de-designated. As a community-based facility, it was misleading in principle and in practice to have it formally regarded as an in-patient psychiatric unit and there seemed to be no reason why patients could not be taken in for respite care or down-loaded from the Mercy Unit without the necessity of formal admission. It was also felt that many of the residents here did not require this level of support and that more appropriate small-scale, community-based accommodation was more appropriate to their needs. Here again, a specialised rehabilitation team to evaluate in a formal fashion their precise needs, social and clinical, should be in place.

There were 178 involuntary admissions to this service in 2001, of which 172 were on temporary certificates, one was a PUM and five were Wards of Court. Twenty-four patients admitted as involuntary patients were re-graded to voluntary status during the course of their hospitalisation. Five patients admitted as voluntary patients were re-graded to involuntary status during their in-patient stay. There were fourteen extensions of involuntary admission forms in 2001. Of the 1,141 discharges, twenty-six patients took their own discharge against medical advice and appropriate follow-up procedures were in place if deemed clinically appropriate. There were four deaths in the service in 2001, all from natural causes. There were six complaints and eight requests under the Freedom of Information Act made to the local complaints appeals manager during 2001. All appeared to have been dealt with satisfactorily. There were no research projects undertaken in this service governed by the Clinical Trials Act 1987-1990. There were eight episodes of seclusion, involving six patients, in 2001. Seclusion took place in the former Our Lady's Hospital. Seclusion had not been used in St Michael's unit or in the newly refurbished intensive care unit, Carraig Mór. Twenty-five patients were placed on special nursing supervision involving duty spans of ten hours or more and there were 610 spans of special nursing supervision in 2001. The policy and procedure in relation to special nursing supervision was under review.

Sixteen patients were prescribed ECT in 2001. There was a detailed policy and procedure relating to ECT and the Royal College of Psychiatrists handbook was available for staff

information and reference. All documentary procedures relating to ECT were satisfactory. There were forty-six recorded accidents to patients and four recorded accidents to staff. Twelve of the accidents resulted in minor scratching or bruising. One accident to a patient was deemed serious. There were three recorded assaults on patients and twenty-eight recorded assaults on staff. One of the patient assaults and one of the staff assaults was deemed serious. There were five incidents of self-harm, four involving mild injury, scratching and bruising, and one deemed serious. The procedure for reporting accidents, incidents and assaults appeared satisfactory. An auditing system should be established for the tracking and trending of accidents, incidents and assaults by date, time and location.

The policy for the ordering, prescribing, storing and administering of medicines required review and updating. Prescription cards examined were of a good standard. Some were in block writing, and those scripted were not difficult to read. All prescriptions were signed and dated individually and the discontinuation column was completed satisfactorily for drugs discontinued. The drug administration recording card should have provision for the nurse's signature in full when next reprinted. There was an increased risk factor of incorrect drug administration in a small number of prescription cards where the discontinued prescriptions were greater in number than current prescriptions. It was suggested that these cards be reviewed and rewritten. Provision should also be made for the recording of drug sensitivities so that information was rapidly available to staff.

Biographical information and nursing assessments were appropriately recorded in the nursing notes, but there was a need for greater correlation between the nursing objectives/goals and the nursing notes. Nursing records should reflect the involvement of patients in planning and making choices and decisions about their care and treatment. Evaluation of nursing care plans should include patients' views about progress. It was suggested that nursing records be audited to assess standards of record and identify areas for improvement and staff development. All newly admitted patients to this service had a full medical evaluation, including comprehensive admission notes, mental state examination, physical examination and clear immediate management plan appropriately recorded in the medical file. The date of record was stated but the time was not recorded. Recording of time is useful in determining any delays in assessment and treatment. The patient's name and identity number should be recorded on each continuation page. No instructions were provided on the filing of documentation within the record. The record folders had an open pocket on the inside of the front and rear covers. In these pockets had been placed numerous documentation, including prescription charts, care plans, observations and other correspondence. Risks associated with the use of pockets include delay in accessing pertinent information, lost or misfiled information, as the contents of the pockets were not secure.

All patients, irrespective of their status must be informed of their rights. Voluntary patients should be told if they wish to leave the hospital they must discuss this with their consultant or, in his or her absence, the clinical nurse manager. The rights of detained patients should be prominently displayed in in-patient care areas and included in a hospital brochure. This service was working on the introduction of a hospital brochure at the time of this visit. Informing patients of their rights included two tasks: the first was to provide

written explanation via patient leaflets or hospital notice boards, and the second was to be satisfied that the patient understood the explanation given. On admission, or as soon as practicable thereafter, patients must be informed of their rights. Ideally, this information should be given in writing, with a verbal explanation of the contents and entries should be made in the patient's nursing documentation that an oral and written explanation had been given, with an indication of the patient's comprehension.

While every patient and their relatives had the right to make a complaint through local procedures, there was a need to ensure that patients were aware of this right and were aware of the procedures and the name of the local complaints officer. This information should be incorporated in the revised hospital brochure. Similarly, systems should be put in place to ensure patients were adequately informed on hospital charges. There was a smoking policy operational in this service and tobacco products were not issued to patients. Designated smoking areas were available. There was a need to ensure patients in the top unit of the Carraig Mór facility complied with the revised smoking arrangements.

Generally, staff appeared aware of the importance of approved policies and procedures and protocols in reducing the level of risk. The policy and procedure manual was dated 1996 and required review and updating in view of the relocation of this service from the long-stay unit in the former Our Lady's Hospital to new premises at Carraig Mór and St Michael's Unit at the Mercy Hospital. Guidance on the management of illicit drug use or drug-related incidents, setting out action to be taken on suspicion of illicit drug use or supply and a policy for staff to search and confiscate illicit drugs or dangerous weapons and arrangements with the Gardaí re disposal of illicit drugs should be included in the updated policy manual. A policy and procedure relating to patients absent without official leave, indicating when the patient went absent without official leave, who had responsibility to return the patient, the names of the person to take charge of the procedure, organise a local search, contact local Gardaí and contact relatives, was also required.

Safety statements, dated 1996, were available at each location. These required review and updating. Site-specific safety statements should be available at each location. These should include hazard-control sheets and records of periodic safety audits, indicating safety hazards and the names of persons with responsibility for ensuring these issues were addressed. Patients and staff at this location should have an input into the patients' menu cycle, which should be prominently displayed in the patients' dining area. A new pinpoint personal alarm system was installed. Records should be kept of the activation of this alarm.

Two service users were interviewed to assess their opinions of the psychiatric services provided to them. One had a previous admission to psychiatric services elsewhere, while the other had had 'countless admissions'. Both were aged between thirty and forty years. They were satisfied with their admitting process and their introduction to the multi-disciplinary care teams. One was quite happy with the inputs from the medical and nursing personnel and the frequency of their contacts, while the second patient was not happy at all. This patient maintained that never once in all contacts with the consultant psychiatrist

was this on a one-to-one basis and averred that all consultations were made in the company of the multi-disciplinary team members, and this was greatly resented. Neither patient was aware of their rights under the mental treatment legislation, though these were posted up in patient areas, and neither one was aware of any complaints procedures. While occupational, recreational and diversionary activities were available during week-day periods, they were noticeably absent in the evenings and particularly at weekends, and at these times the patients felt quite bored. They were particularly pleased with relaxation therapy and would like to have much more of this.

One patient had no specific suggestion as to how the service could be improved, while the second was very forthcoming in this regard. This patient averred that nurses did not interact sufficiently with patients, apart from notable exceptions, and suggested that secretarial assistants be provided to answer phones and other administrative duties to free up nurses to play a greater role in counselling and psychotherapy. This patient found that psychological inputs were grossly lacking in this service. The Inspectorate was approached by a number of female patients in St Michael’s Unit, requesting access to a hairdresser.

RECOMMENDATIONS

It is recommended that:—

1. A community infrastructure, as envisaged and planned for by the management team, be put in place, with sector headquarters, day hospital and community mental health centre in each sector.
2. Medical, clinical and administrative arrangements in Carraig Mór be rationalised so that a designated and exclusive consultant-led team deal with the intensive care unit and a second, specialised rehabilitation team, as part of more general responsibilities, be responsible for the upper floors of the unit.
3. The Owenacurra residential unit at Midleton be de-designated.

SOUTH LEE MENTAL HEALTH SERVICE — 2002 INSPECTION

INSPECTED ON 13 AUGUST, 2002

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 167,638 was divided into six sectors as follows:

Sector	Population
City South-East	28,662
City South-West	25,591
Bandon/Kinsale	29,075
Bishopstown	20,217
Ballincollig	17,502
Douglas/Carrigaline	46,591

IN-PATIENT CARE

Acute in-patient care was provided at the Department of Psychiatry, Unit GF, of Cork University Hospital (CUH), which had forty-six beds. Continuing care was provided at St Finbarr’s Hospital, which had forty-four beds in two integrated units.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	4	22	24	5	—	55	55.5
3 to 12 Months	—	—	4	—	2	—	6	6.1
1 to 5 Years	—	—	1	5	1	—	7	7.1
Over 5 Years	—	—	4	15	9	3	31	31.3
All Lengths of Stay	—	4	31	44	17	3	99	100
% of Total	—	4.0	31.3	44.4	17.2	3.0	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
4	30	11	23	12	8
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
2	3	—	5	1	99

Status of In-Patients on the date of inspection 2002

Status	Male	Female	Total
Voluntary	38	44	82
Temporary	8	15	23
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	46	59	105

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
678	4.1	212	31.3	78.9	21.1	593	2

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of Persons Attending
Day Hospitals	1	25	274
Day Centres	1	15	89
Out-patient clinics	7	1,003*	1,997

*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
5	16	1	6	2	20

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
17.33	8	110.30	7	7

COST

The cost of the South Lee Mental Health Service was €8.3 million in 2001.

GENERAL COMMENTS

This service had, at last, been sectorised and now comprised six sectors. Unfortunately, other than a day centre at Bandon, a limited day hospital operation at Ravenscourt in St Finbarr’s Hospital and a small mental health resource centre, newly created and of regrettably narrow focus, at Ballincollig, the six sectors had nothing of community mental health assessment/day hospital/sector headquarters structures in place and only a limited multi-disciplinary character to all six sector teams. Later in 2002, a specialised psychiatric service for older persons was to commence operation. There was no sub-unit for acute assessment purposes for this service within the overall acute unit in Cork University Hospital, though one supposed that a number of beds on each of the two floors of the unit would be allocated for this purpose. This pointed out, once again, the generally unsatisfactory structural nature, for modern acute care, of Unit GF, particularly in regard to the absence of adequate observation facilities for acutely ill patients. This, combined with the lack of a safe room for close observation purposes, no doubt accounted in part for the disproportionate transfer or admission rate from this catchment area and from the unit to the Carraig Mór intensive care unit. The later-life psychiatric service had been allocated, it was reported, some office accommodation in the replaced occupational therapy unit attached to the main acute unit.

There was still a large influx of self-referred and other-referred patients to the unit in a haphazard fashion. Such patients were not directed through A & E, so no triage or physical examination took place outside the unit. This, of course, was compounded by the lack of mental health centres in the sectors to which patients could be referred for assessment purposes. Patients thus arriving directly at the unit were assessed by junior doctors and it

did not seem to the Inspectorate that, as a routine, consultation with consultants by NCHDs who did the assessment took place. Accordingly, it was inevitable that some inappropriate admissions took place because of this. It led, from time to time, to a scarcity of admission beds, so that patients were transferred either to St Catherine’s unit in St Finbarr’s or to Carraig Mór, where this catchment area had by far the highest referral rate. These transfers were undesirable and should be eliminated.

Case note structuring, ordering and sequencing in the unit was unsatisfactory. Documentation was lacking in indicating paths to admission, the minutiae of the decision-making process, whether a consultant was consulted or not. A clearly outlined intake assessment, evaluation and a shared programme approach with the patient was not evident in the case notes. Numerical ICD diagnoses were also missing in diagnostic work-ups and it was felt that a formalised assessment and care- programmed approach was, for the most part, lacking.

St Catherine’s unit in St Finbarr’s Hospital, which was essentially a long-stay residential facility, had a small number of admissions surfing over the predominantly long-stay population. It was an approved unit on the register of such units and therefore admitted patients on Mental Treatment Act, 1945 forms. This should be discontinued and the unit de-designated. When it was necessary to admit a patient for respite care or for ‘step-down’ residential care before discharge, this could be done informally. The premises itself was of poor quality as a residential unit, both in its upstairs structure where day care was provided and in the separation of the sleeping quarters, which were in another part and on the ground floor of the building. This pointed up the absence of a specialised rehabilitation approach and team for patients with continuing disabilities in this catchment area.

The Inspectorate had a similar view of St Monica’s Unit, also in St Finbarr’s Hospital and, again, would like to see this unit de-designated and looked after by a specialised rehabilitation team.

There were 143 temporary admissions to Cork University Hospital in 2001, 103 of whom were re-graded to voluntary status during their hospital stay. Involuntary admission forms checked at random were completed satisfactorily. There were 577 spans of special nursing supervision, involving twenty-three patients in Cork University Hospital in 2001. Seclusion was not used in this service, but the service had access to the intensive care unit at Carraig Mor in the refurbished former St Anne’s Hospital, Shanakiel. There were five complaints made by patients or patients’ relatives and twelve freedom of information requests made to the local complaints appeals manager during the year. All appeared to have been dealt with satisfactorily. There were no research projects undertaken in this service governed by the Clinical Trials Act 1987-1990. Eight patients were prescribed ECT therapy at CUH in 2001. There was a policy and procedure for ECT, with a named consultant psychiatrist responsible for the ECT clinic. A pre- and post-ECT nursing checklist and consent form were all satisfactory. Statistical information relating to patients taking their own discharge from the service was not available at the time of inspection.

There were thirty recorded accidents to patients and two recorded accidents to staff in the South Lee mental health service in 2001; none were deemed serious. There were nineteen self-inflicted injuries to patients, involving minor injuries such as scratching and bruising; none were deemed serious. There were six assaults on patients by other patients and seven assaults on staff. Six of the assaults, four on staff and two on patients, resulted in mild injury; none were deemed serious.

There was a written policy for the ordering, prescribing, storing and administering of medicines. Prescription writing was generally satisfactory. Prescriptions were written in block writing and those that were scripted were not difficult to read. All prescriptions were signed and dated individually and the discontinuation column had one date and one signature for each prescription. The storage area and transport system for medicinal products between units was satisfactory. There was provision for the recording of drug sensitivity so that information was rapidly available to staff. The drug administration recording card should have provision for the nurses' signatures in full when next reprinted.

The nursing records should be audited to assess standards of record and identify areas of improvement and staff development. A care planning system was in operation at Unit GF, using the Roper model of nursing. While all entries were accurately dated, the time of entry should also be recorded. The accuracy of the patient's name, date of birth and address was appropriately recorded on the nursing record. There was a need for a greater correlation between the nursing goals and the nursing notes. Nursing notes should reflect the involvement of the patients in planning and making choices and decisions about their own care and treatment. All records confirmed that patients appeared to settle well into the ward at the end of the first day of hospitalisation. While records were written clearly so that text could not be erased, efforts should be made to ensure that they were readable on photocopies. It was hoped to develop the Tidal Model of Nursing Assessment and Care in Unit GF similar to projects being developed elsewhere in the catchment area.

All patients, irrespective of their status, must be informed of their rights. Voluntary patients should be told that if they wish to leave hospital they must discuss this with their consultant or, in his or her absence, the clinical nurse manager. The rights of detained patients should be prominently displayed in in-patient care areas and included in a hospital brochure. There was no hospital brochure and no information on rights at Unit GF at the time of this inspection. Informing patients of their rights contained two tasks: the first was to provide written explanation via patient leaflets or hospital notice boards, and the second was to be satisfied that the patient understood his or her rights. On admission, or as soon as practicable thereafter, patients must be informed of their rights. Ideally, this information should be given in writing, with a verbal explanation. The records should indicate that this has happened. If the patient was clearly incapable of understanding, this should be recorded in the notes and information should be repeated at regular intervals, using professional judgement relating to the patient's capacity for understanding.

Appropriate emergency resuscitation equipment was stored at a strategic location within Unit GF. The equipment and emergency medical preparations were checked weekly to ensure that equipment was in working order and medicinal preparations were within date.

There was a fire and safety committee within the service, which met regularly. Appropriate minutes of meetings were kept. Training courses on CPR, safe lifting and manual handling of loads, and the management of aggression and violence were available for all staff. Safety statements were dated 1995 and required review and updating. The Inspectorate was informed of a recent safety audit at Unit GF. Copies of hazard-control sheets, any low, medium, and high-risk safety hazards should be available to local ward managers. The name of the individual with responsibility for addressing identified hazards should be clearly stated and an appropriate action plan to rectify identified hazards should also be recorded. Each in-patient care area had a designated smoking location and smoking was not permitted in non-smoking areas. This appeared to be rigidly enforced and patients and staff working together ensured compliance. The patients' money-management system examined appeared satisfactory, but there was a need for a formal system of informing patients of hospital charges. The service should consider introducing systems for seeking feedback from patients and families on service provision.

The importance and value of policies, procedures and similar documentation within this service was recognised. All policies, procedures and guidelines required review and updating. Each policy should be headed with the hospital title, individually numbered, the date of ratification and by whom recorded, with an appropriate review and audit date. All policies, procedures and guidelines should have a truly multi-disciplinary focus. A policy relating to patients absenting themselves without official leave from the in-patient unit, indicating when a patient went absent without official leave, who had responsibility to return the patient, who took charge of the procedure, how a local search was organised and who led the search, when and who contacted the Gardai, and when and who notified the patient's relatives, should be included in the revised and updated policy manual.

One patient was interviewed in the Department of Psychiatry, Cork University Hospital, to assess his view of the psychiatric services provided. This admission was his seventh to this facility and he was fulsome in praise of the service provided, apart from some disgruntlement with the consultant psychiatrist at not being discharged. The patient was wearing night clothing and readily appreciated this was to prevent absconding, which was admitted to have been contemplated. All this patient's admissions were in a voluntary capacity. A key nurse was assigned and all the nurses were extremely helpful. A charter of patients' rights under mental health legislation was posted up in patient areas. While occupational therapy and daily therapeutic activities were appreciated, the lack of same at weekends led to boredom. The nature of the patient's illness and the effects of the prescribed medication had been adequately explained. The patient was fully aware of the function of the Inspectorate and felt its work was a great asset to the psychiatric services. When asked to make suggestions for the improvement of the service, he replied, 'I am quite happy. The nurses are marvellous. I have no complaints.'

RECOMMENDATIONS

It is recommended that:—

1. A community mental health centre be set up in all sectors of the service, to be used for assessment and other purposes, in combination with a sector headquarters and day hospital.

- 2. St Catherine’s and St Monica’s units be de-designated.
- 3. The residents of St Catherine’s and St Monica’s, and all others who require it, be in the care of a specialised rehabilitation service for the South Lee catchment area.

WEST CORK MENTAL HEALTH SERVICE — 2002 INSPECTION

INSPECTED ON 10 AND 11 SEPTEMBER, 2002

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 50,914 was divided into two sectors as follows:

Sector	Population
Skibbereen/Clonakilty	27,322
Bantry/Dunmanway/Schull/Castletownbere	23,592

IN-PATIENT CARE

In-patient care was provided at the eighteen-bed psychiatric unit in Bantry General Hospital.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	—	6	5	3	—	14	93.3
3 to 12 Months	—	—	1	—	—	—	1	6.7
1 to 5 Years	—	—	—	—	—	—	—	—
Over 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	—	7	5	3	—	15	100
% of Total	—	—	46.7	33.3	20.0	—	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	7	1	6	—	—
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
—	1	—	—	—	15

Status of In-Patients on the date of inspection 2002

Status	Male	Female	Total
Voluntary	10	4	14
Temporary	1	2	3
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	11	6	17

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
276	5.4	81	29.3	91.7	8.3	292	—

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of Persons Attending
Day Hospitals	—	—	—
Day Centres	1.2	33	468
Out-patient clinics	7	147*	297

*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
5	24	3	29	1	28

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
7	4.5	62.5	13	5.33

COST

The cost of the West Cork Mental Health Service was €4.2 million in 2001.

GENERAL COMMENTS

Since the 2001 inspection, the catchment area of the West Cork service had been extended by the transfer of a small population segment of the western-most end of the South Lee catchment area. The service suffered from a lack of day hospital and other services, but some of this, was being addressed. There was a shortage of nurses, so that the nurse establishment of sixty-eight was running at fifteen per cent shortage because of unfilled, and apparently unfillable, vacancies. These difficulties, in combination, militated against outreach community-based programmes and home care and led to inappropriate in-patient

admissions. An attempt had been made by the service to introduce a skill-mix arrangement, whereby the nursing vacancies would be filled by nursing assistants, but this had been strenuously opposed by the nursing representative bodies and management had, apparently, abandoned the idea in the face of this opposition. Further staffing difficulties included the recent departure of a psychologist/counsellor and the inability to fill a second social worker post. After a number of years when no permanent consultant had been in post, a recent permanent appointment was now leaving and, once again, the service would revert to having neither a permanent clinical director nor a consultant. The Inspectorate perceived this to be a serious liability. There were also difficulties in recruitment at junior hospital doctor level and at psychologist and occupational therapist level.

The Psychiatric Unit at Bantry General Hospital had recently become an approved institution for the reception of persons of unsound mind and this had created a great deal of anxiety among staff who, over the years, had grown to accept that difficult or troublesome patients were either not admitted to the unit or, if admitted, were transferred to locked accommodation in Cork City. Faced with the prospect of having to deal with a wider range of patients than heretofore, staff were anxious and apprehensive at the prospect. Unfortunately, some of these fears were justified, in that there was no close observation or safe accommodation facility in the unit. The Inspectorate felt that this was essential to cater for ill and disturbed patients.

Some satisfactory developments were also in prospect on the community side in Bantry. The provision of the new community residence, Ard na Realt, was a major advance and this attractive building would shortly open to take ten patients currently resident in another community residence in Bantry, Cois Cuan. On doing so, the current day centre premises in Drumleigh, would move to Cois Cuan and further steps would be taken to upgrade Drumleigh to serve, inter alia, a day hospital function. A further project in prospect was the building by a group headed by the Bantry Mental Health Association of a community residence on land currently owned by the health board, down the hill from Ard na Realt. Further down again on this plot of land, there was a project designed to provide a comprehensive generic health centre for Bantry. The Inspectorate felt that consideration should be given to incorporating a psychiatric component in this building, sufficient to provide a sector headquarters for the Bantry sector and, possibly, a day hospital as well. Two rooms would be made available in a generic health centre in Clonakilty and this could be expanded to provide a sector headquarters and day facility in that centre as well as in Bantry.

One patient in the psychiatric unit at Bantry General Hospital was interviewed to seek his opinion on the psychiatric services provided. This patient had many admissions previously to the unit, some of which were involuntary. On this occasion, the patient was of voluntary status and was currently nine days in hospital. He was pleased with the admitting procedure and was introduced to his primary nurse. He was well acquainted with his consultant psychiatrist and had consultations on a very frequent basis. He was given an information leaflet on the hospital containing rules, procedures, etc. Through this, he became aware of his rights under the mental health legislation and also of the complaints procedure obtaining. He never felt bored in the hospital and felt the therapeutic activities

were ‘brilliant’. He was always treated with respect and dignity and never at any time felt his privacy was invaded. He was extremely complimentary about the nurses and was quite au fait with his medical condition and his medication, side effects, etc. He did have some side effects to his medication, but his doctor rectified these. When asked how he would like to see the services improve, he said, ‘No patient should ever be transferred from this unit to any Cork hospital.’ He obviously had been transferred on previous occasions to a more secure unit in Cork and he did not relish the experience. He also felt the periods of occupational therapy should be increased and should include outdoor games. While he considered the food quite good, he would appreciate a greater choice for evening meals.

Twenty-three patients, nine male and fourteen female, were admitted involuntarily to the West Cork mental health service in 2001. Sixteen of those admissions were regraded to voluntary status during the course of their hospitalisation. Ten patients were admitted to the psychiatric unit following liaison consultations in the local general hospital, and a further sixty patients were referred following consultation to the out-patient department. Fifteen patients were transferred from the unit at Bantry General Hospital to Our Lady’s Hospital in Cork. Two patients took their own discharge from the service last year against medical advice and appropriate procedures were in place to follow up these and other patients if deemed clinically appropriate.

Electro-convulsive therapy was not prescribed for any patients in this service in 2001. There was a dedicated ECT suite and a policy and procedure on ECT. However, it was noted that ECT had not been prescribed in recent years. Five patients were placed on special nursing supervision — one nurse supervising one patient continuously — and there were fifty-six spans of special nursing supervision. The policy and procedure relating to special nursing supervision was under review at the time of this visit. It was suggested that all decisions regarding observation should be recorded by the doctor or nurse in the patient’s main medical or clinical notes, and records should include the patient’s current mental state, current assessment of risk, and specific observations to be implemented. Clear directions regarding the therapeutic approach, i.e., occupation, therapy sessions, and timing of next review, should also be documented. Detailed records of observations should be kept by staff responsible for carrying out observation, including the name of the person responsible and the time they commenced and concluded their period of observation. A detailed record of the patient’s behaviour, mental state, and attitude to observation should be recorded, as should the reason for observation, length of time observed, and any untoward incidents. Records should also be kept of the patient’s views of the process of observation and the nurse’s views of the process should also be recorded in order to improve the implementation of observation.

Seclusion was not used in this service. However, it was felt that this service should have access to a dedicated safe room for emergency purposes only, in the interests of the safety and welfare of patients and staff.

There were three recorded complaints/appeals made by patients or patients’ relatives to the local complaints manager in 2001. In addition, four requests were made under the Freedom of Information Act. All appeared to have been dealt with satisfactorily. There

was a named person responsible for dealing with complaints and requests under the Freedom of Information Act. While there were notices prominently displayed informing patients about their statutory legal rights under the Mental Treatment Act, 1945 and amending legislation, the giving of information on rights to detained patients should be recorded in the case notes. A standardised form should be considered for inclusion in the case notes to record that information had been given to patients about their legal position and rights under the mental treatment legislation. This form should have space for recording the name of the person giving the information, the date the information was given, whether the patient understood the information, and subsequent attempts to give the information. The difficulties of explaining legal matters to patients whose mental state might preclude the understanding or retention of such information were acknowledged. While services were sensitive to the capacity of each individual patient, and rights were explained as far as possible in a way the patient understood, it was the Inspectorate's view that all attempts to pass on information on patients' rights should be recorded.

The accident and incident reporting system in this service appeared satisfactory. All injuries were classified according to seriousness of outcome. There were ninety-four recorded accidents to patients, including self-inflicted injuries. Forty-one resulted in mild injury, scratches or bruising, and four were deemed serious. There were four recorded accidents to staff, three involving lifting of patients, resulting in mild injury, and one, a needle-stick injury, that was deemed serious. There were six recorded assaults on patients by other patients, all resulting in no apparent injury. There were seven recorded assaults on staff by patients, three of them resulting in minor injuries and four were deemed serious.

The Inspector's Report for 2001 commented that the medical case note records contained no written instructions as to how the case notes should be organised, how entries should be made and how records and medical investigation reports by other staff should be filed. It was also noted that the medical case note documentation was of poor quality. It was pleasing to report that a new filing system, with written instructions on filing of documentation within the record, was being introduced and it was expected all files would change over to the new system as soon as possible. On examination of existing files it was noted that all newly admitted patients had a full medical evaluation, including comprehensive admission notes, mental state examination, physical examination and clear immediate management plan. This was very satisfactory. A discharge advice letter was sent to the GP and other persons responsible for the patient's follow up on the day of discharge, and copies of discharge summaries were easily available in the medical file. An information form was given to patients on discharge, listing prescribed medicines and an appointment at the out-patient clinic.

There was a hospital brochure setting out pertinent information. This brochure should be reviewed and updated. Patients at Bantry General Hospital had ready access to fresh air and to the local shop. There was a need for a designated smoking area within the Bantry unit, and the rest of the unit should be deemed non-smoking. The safety statement in the Bantry unit was reviewed and updated in 2001. All outdated and superseded safety statements should be removed from the clinical area and stored in a central file for future reference. The management team of this service met on a monthly basis and minutes were

kept. There was a fire and safety committee that had last met in June 2002. Recent safety audits had been conducted and copies of hazard control sheets identifying high, medium and low risks, with the name of the action person identified were available. There was an induction process for new staff and appropriate records were kept. The emergency trolleys were stored at appropriate locations and checked regularly to ensure drugs were within current date and equipment was in working order.

The importance and value of policies, procedures and protocols had been recognised in this service. All staff appeared aware of the importance of approved policies and procedures. At the time of this inspection, all policies, procedures and protocols were under review.

The nursing documentation was being audited to assess standard of record keeping and identify areas for improvement and staff development. A new eclectic nursing model was about to be introduced. As persons using the mental health service at Bantry General Hospital were patients as defined under the Mental Treatment Act, 1945 and amending legislation, the word ‘client’ should be removed from all nursing in-patient documentation and the word ‘patient’ substituted. All entries in nursing documentation examined were accurately dated. Each patient was assigned a key nurse on admission; the name of that nurse should be recorded in the nursing notes. Nursing notes should be readable on photocopies. Abbreviations were not noted in the notes examined. Records examined appeared to identify problems that had arisen and actions taken by staff to rectify them. All entries were made as soon as possible after events to which they related, and notes were made relating to how patients settled into the ward at the end of their first day of hospitalisation. Ideally, nursing 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 progress.

The written policy for ordering, prescribing, storing and administering medicines was under review. The standard of prescription writing was varied; some were in block writing and some scripted prescriptions were not difficult to read. There was a moderate risk factor of drug error with a small number of scripted prescriptions that appeared difficult to read. While all prescriptions were signed and dated individually, some required the full signature of the prescriber. The discontinuation column was not always completed for drugs discontinued. There was an increased risk factor of drug error in a number of cards where discontinued prescriptions were greater in number than current prescriptions. The cards recorded drug allergies and drug sensitivities so that information was rapidly available to staff and the drug administration and recording card had provision for the nurse’s signature in full.

RECOMMENDATIONS

It is recommended that:—

1. A design team be set up to put a safe room or safe area in place in the psychiatric unit at Bantry General Hospital.

2. A programme of skill mix be put in place to free up nurses to enable them to become part of an assertive outreach and home care programme of service delivery.
3. Permanent consultant medical staff be appointed, including a clinical director.
4. Day hospital and sector headquarter premises be established in both sectors.
5. The rehabilitation teams recommended by the Inspectorate for the other Cork services should involve West Cork in their activities.

CHAPTER NINE

Western Health Board

EAST GALWAY MENTAL HEALTH SERVICE — 2002 INSPECTION

INSPECTED ON 21 AND 22 MAY, 2002

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 91,619 was divided into four sectors as follows:

Sector	Population
Gort/Portumna (Sector A)	20,762
Loughrea (Sector B)	21,627
Ballinalsoe (Sector C)	24,149
Tuam (Sector BC)	25,081

IN-PATIENT CARE

In-patient care was provided at St Brigid’s Hospital, Ballinasloe, which had 308 beds in six male, three female and six integrated wards.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	—	15	12	3	2	32	12.04
3 to 12 Months	—	1	6	7	5	1	20	7.52
1 to 5 Years	—	—	3	14	4	8	29	10.90
Over 5 Years	—	—	12	50	66	57	185	69.54
All Lengths of Stay	—	1	36	83	78	68	266	100
% of Total	—	0.37	13.2	31.34	29.43	25.66	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
15	121	5	20	13	15
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
6	12	—	57	2	266

Status of In-Patients on the date of inspection 2002

Status	Male	Female	Total
Voluntary	146	92	238
Temporary	9	4	13
P.U.M.	8	5	13
Ward of Court	4	5	9
Total	167	106	273

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
655	7	177	27	81	19	642	26

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of Persons Attending
Day Hospitals	4	Not supplied	725
Day Centres	6	127	221
Out-patient clinics	12	423*	1,432

*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
31	120	10	57	8	90

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
15	33	326.5	205.5	17

COST

The cost of the East Galway Mental Health Service was €26.2 million in 2001.

GENERAL COMMENTS

Because of the Inspectorate’s concern over many years on conditions pertaining in St Brigid’s Hospital, Ballinasloe, and the lack of improvement in matters in that hospital over recent years, the Inspectorate decided to interview senior members of staff individually to ascertain from them their views as to why matters had not improved. In the course of the two days of inspection, as well as inspecting all in-patient locations and a sample of community services in Ballinasloe, the Inspectorate interviewed in a formal manner senior members of the management team of the service.

As a result of these interviews, the Inspectorate formed the view that the senior management at St Brigid's Hospital was unable to make progress in improving the service because of obstruction by nursing representative bodies and by a perceived lack of support for the management team's initiatives by senior Western Health Board management when the nursing organisations intervened, as they frequently did, to obstruct and impede progress. In many instances exemplifying this state of affairs, senior figures in St Brigid's individually informed the Inspectorate that they had collectively formulated a policy and plan towards down-sizing and re-arranging wards in St Brigid's with a view to the provision of improved and alternative care facilities. When, in December of 2001, they presented this plan to the nursing representative bodies, they were informed, in no uncertain terms, that the nurses would not co-operate in the introduction of any of the mooted changes and that should hospital management attempt to introduce them, there would be immediate, widespread industrial action. In the light of this threat, a representative of senior management of the WHB came to St Brigid's, met with senior local management, and suggested that the status quo should remain whilst engaging fully with staff representatives. In effect, nursing representative bodies had virtual control of anything that happened, or did not happen, and therefore local management felt powerless and disenfranchised. It had thus proved impossible to improve conditions in St Brigid's and to move forward with any major plan of improvement.

Conditions in Wards 1, 2, 3 and 5 could only be described as a deplorable blot on the health services of this country. Ward 1 should long ago have closed; it was used as a male, locked ward, was barren, devoid of any reasonable furnishings or decoration and its occupants remained in this throw-back to the large mental hospitals of a century ago, unoccupied and idle, for the most part. No rehabilitation or serious occupational activities were in place for patients. The ward contained only nine patients, all of whom could, in the view of the Inspectorate, be accommodated in other, better settings. One patient was intellectually disabled and was quite inappropriately placed with mentally ill persons. The ward was used for both admission and long-stay purposes, with some persons being admitted directly to the ward from the community and some being transferred from the admission ward to it.

This was not appropriate and, in the view of the Inspectorate, all admissions should be dealt with in the admission area. It was unclear who, in all circumstances, made the decision to admit a patient to this ward. One patient who had been admitted several weeks previously had not been seen by a consultant, or at least there was no evidence in the case notes to indicate that he had. Another had been seen by a consultant who recorded the comment that he should remain several weeks in the unit, thereby indicating that any review in the interim would be futile in relation to transferring him to more salubrious surroundings.

Wards 2 and 3 contained high proportions of intellectually disabled persons, mixed with those with mental illness. Here, again, conditions were physically very poor and patients had no opportunity of sustained occupation, diversion or rehabilitation. The same story was repeated in ward after ward of the old hospital, although physical conditions were not as abject as in some of the other wards. Very few of these patients left the wards to

get fresh air or to go to rehabilitation activities and most of them spent their days unoccupied. The Department of Health and Children had, several years previously, attempted to put a rehabilitation programme in place, based on Unit 9 in Merlin Park Hospital, for long-stay patients from St Brigid's, particularly those from West Galway, but after an initial flurry of activity, Unit 9 had become simply a long-stay high-support residence, in addition to being used as an overflow for admission patients from the psychiatric unit in University College Hospital, Galway. A further attempt to introduce a rehabilitation team to the East Galway service, which had been initiated several years ago, was only now beginning to bear fruit with the imminent arrival of a consultant specialising in rehabilitation.

Several times over the lifetime of this Inspectorate, attempts had been made to persuade the service to de-designate the New Building as part of a specialised component of services for older persons in East Galway. Attempts to do so had progressed substantially in 1992 until, once again, the nursing representative bodies intervened and stymied the attempt. The need to resurrect such an initiative was now all the more relevant as fifty-five per cent of the 273 residents in St Brigid's were, on the day of inspection, aged over sixty-five years and thirty per cent were over seventy-five years. However, it was some relief to hear that a psychiatrist specialising in later-life psychiatry was shortly to take up post.

St Brigid's Hospital had, in addition to the high resident rate of almost three per 1,000 of population (the highest in the country), an unacceptably high admission rate of seven per 1,000 of population. This, it was understood, was because of the lack of an implemented admission policy and the flow of persons into the admission units for assessment being referred there by GPs, often without prior warning, or, alternatively, being self-referred. Many of these persons came for detoxification from alcohol dependence and all were, apparently indiscriminately, admitted. The newly created admission wards consisted of an acute and a sub-acute unit. The Inspectorate did not understand the rationale for acute and sub-acute units. An acute admission unit should be, as the name suggests, for acute purposes only. Confusingly, some admissions did not come to the acute unit but were admitted directly to the sub-acute unit and all persons admitted to the acute unit had to be transferred from there to the sub-acute unit before discharge, compounding the lack of continuity of care already evident in many aspects of the functioning of St Brigid's. The admission units themselves were cramped and uncomfortable and were poor substitutes for a planned and purpose-built admission unit. The Inspectorate had been seeking the provision of such a facility in Portiuncula Hospital for several years but, after some early progress, any further advance in the matter seemed to have slipped away, at least for the time being.

Nursing staff both at St Brigid's and in the community services worked a day on and a day off roster, which was seriously compromising effective and efficient patient care. Discontinuities arose under other circumstances also; overtime to cover up discontinuities was widespread and was one of the contributors to the inordinate cost of running this service for fewer than 100,000 persons, at over €26 million in 2001, representing extremely poor value for money in terms of what was delivered to patients. With the arrival of some new consultant specialists in the areas of rehabilitation and later-life psychiatry, an

improvement in medical care was to be expected. An attempt was also being made to recruit a psychiatrist with a special interest in learning disability and, given the numbers of intellectually disabled persons in the East Galway service, and indeed in the rest of the WHB service, this was a very welcome and necessary move forward.

Community-based facilities in the Ballinasloe area were visited and the high staffing ratios and illogical rostering that operated in many of them were noted. Attempts by senior nursing administration to deal with such matters, including introducing appropriate skill mixes in operational matters, had also been frustrated by nursing representative bodies, the Inspectorate was informed. The newly opened Ballinasloe day hospital was visited. It was located in a generic, comprehensive health centre in the centre of Ballinasloe, but it was disappointing to find that the design did not allow it to deal with serious or severe mental illness; the extent of office provision to the detriment of patient space was noted. The Inspectorate was told that an out-patient clinic was held here one morning a week and that three medical interviewing offices had been made available for this purpose. For the rest of the week, these rooms apparently had no other usage. Apart from this obvious waste of space, the principle of running out-patient clinics from a day hospital setting was one that did not meet with Inspectorate approval. It was clear that those who designed this day hospital did not understand what the purpose of a day hospital was, or how it should operate.

Elsewhere in the catchment area, difficulties had been encountered in setting up a sector headquarters and day hospital in the Portumna sector. Criticisms similar to those voiced about the Ballinasloe day hospital were also appropriate in the case of the Tuam day hospital and have been set out in detail in the 2001 Inspector's Report. The Loughrea day hospital had the potential to deal with more seriously ill persons and had, to some degree, taken on this task. Here again, it could not be said that it functioned as a sector headquarters or mental health centre. It was essential that the sectors in the East Galway service each contained a mental health centre and sector headquarters out of which the multi-disciplinary professional teams worked and to which GPs and others could refer cases for assessment, rather than having persons arrive up, unplanned, at the admission unit at St Brigid's, where admission, instead of alternative, more appropriate, arrangements, was almost always assured.

There was a part-time senior psychologist and other full-time psychologists in place in the service, together with a senior social worker and support staff. However, there was no occupational therapist.

Even though the 'overflow' of admissions to St Brigid's Hospital from the West Galway catchment area had reduced in recent years, it was still sizeable. Much of this related to PUM admissions, which came under Garda escort to St Brigid's because the psychiatric unit in University College Hospital, Galway, was not designated a District Mental Hospital under the Mental Treatment Act, 1945. It intended pursuing its registration for this purpose to close off this loophole and the problems it created for the East Galway service.

There were twenty-six deaths at St Brigid's Hospital in 2001, all from natural causes. There were no deaths of hospitalised patients by suicide. Eighteen patients took their own discharge from the hospital against medical advice during the year. There were seventy-one temporary admissions and fifty-four PUM admissions in 2001, and six temporary admission orders were extended during the same year. Twenty patients admitted voluntarily were regraded to temporary and thirty-three patients admitted involuntarily were regraded to voluntary status during their period of hospitalisation. Eleven patients became new long stay in 2001, that is, were continuously hospitalised for longer than one year and less than five years; five of those patients were aged sixty-five years or over. There were forty-two recorded accidents to patients and twelve recorded accidents to staff during 2001; none were deemed serious. Of the four recorded assaults on patients by other patients and the fourteen recorded assaults on staff, none were deemed to be serious. Sixty-three patients were prescribed ECT treatment at St Brigid's Hospital in 2001. There was a dedicated ECT suite in the admission complex, which, although not ideal, was reasonably satisfactory. A written policy and procedure on ECT was reviewed and updated in 2001. The Royal College of Psychiatrists Handbook and notices relating to ECT were available in the treatment area. There was a named consultant responsible for the ECT clinic and an induction process for new medical staff. The pre- and post-ECT nursing checklists were all completed satisfactorily, as were all of the consent forms examined. All ECT treatments were pre-arranged and patients were not kept waiting, which was very satisfactory. The nurse in the recovery area had had training in basic life support.

There were twenty-three episodes of seclusion involving one patient at St Brigid's in 2001, as compared to twenty-seven episodes involving three patients from 1 January 2002 to the date of this inspection. All of the seclusion episodes took place at Ward 1 where the facilities were far from ideal. There was evidence of smoking in the seclusion room, with burn marks on the floor and the walls. There were also graffiti etched into the wall and the rooms themselves were in a poor state of décor. The nursing records of fifteen-minute observations of patients while in seclusion did not indicate when seclusion commenced or terminated. Otherwise, nursing observations were appropriately recorded. A seclusion register was maintained. In some instances, on examination of the register, seclusion was approved from 8.00 a.m. to 11.00 a.m., 12 noon to 2.30 p.m. and 5.00 p.m. to 8.00 p.m. and from an examination of the nursing records it appeared that seclusion continued throughout. One page was appropriately signed, authorising seclusion, but did not contain the patient's name. The whole system required review and the Inspectorate suggested a regular audit of the use of seclusion. The policy and procedure relating to seclusion was dated 1996 and should be reviewed and updated. It is worth mentioning that two safe rooms had been upgraded at Ward 5. These were of far better standard than the rooms available in Ward 1. The rooms in Ward 5 had not been used for seclusion purposes.

Forty-one patients were placed on special nursing supervision, involving one nurse supervising one patient, and there were 714 episodes of special supervision in 2001. There was a written policy on special nursing supervision, dated 1996, which required updating. The policy and procedure manual relating to patient care appeared to focus specifically on nursing issues and was dated 1996. Policies and procedures should have a truly multi-disciplinary focus as they are all related to clinical risk assessment and clinical risk management. All of the existing policies and procedures should be reviewed, updated and made

available in clinical areas for the information of all members of the multi-disciplinary team. Guidance on the management of illicit drug use or drug-related incidents, setting out action to be taken on suspicion of illicit drug use or supply, and a policy for staff to search for and confiscate illicit drugs or dangerous weapons, and arrangements re disposal of illicit drugs, should be included in the policy guidelines. Policy guidelines should also contain information for staff on the locking of external ward doors, patients' voting rights and all other matters pertinent to a patient's journey through the hospital system. Information relating to staff rosters, absenteeism control, and other staffing issues should not be contained within the clinical policy and procedure manual.

The provision of designated smoking areas within the admission unit complex, and the fact that smoking appeared to be confined to these areas, was very much welcomed. A number of wards in the long-stay block had no designated smoking facilities and, in some wards that had, it was noted that the smoking policy was not rigidly enforced, as there was evidence of smoking in bedrooms, dining rooms, non-smoking sitting rooms and corridors. All of this required attention.

The patients' money management systems within St Brigid's appeared satisfactory and the Inspectorate welcomed the introduction of notices in the admission areas informing patients of hospital charges. It was hoped that this information was brought to the attention of individual patients. Information on patients' rights under the Mental Treatment Act, 1945 should be prominently displayed in clinical areas and brought to the attention of patients. One way of doing this is to include the information in a hospital brochure containing pertinent information relating to a patient's stay in hospital. Copies of the hospital brochure, with full details of hospital services, were not available in the admission unit at the time of this inspection. The WHB Safety Statement, dated 1993, and the hospital safety statement, dated 1996, were available in all clinical areas. In addition, there was a site-specific local safety statement, undated. Records of safety audits were kept at each clinical location, indicating identification of various safety hazards and actions required to address the hazards identified. Emergency resuscitation boxes with resuscitation equipment and medication were stored at appropriate locations. All medicines were checked regularly by the pharmacy to ensure emergency medications were within expiry date. This system was very satisfactory. The safety committee met quarterly and minutes of meetings were kept. Fire safety was incorporated into the health and safety meetings and reviewed as part of that programme. There was a comprehensive policy and procedure for patients absent from St Brigid's Hospital without official leave, indicating the responsibility of staff to return such a patient, who took charge of the procedure, how a local search was organised, who contacted the Gardai and the patient's relatives. This comprehensive policy and procedure was unsigned and undated and was not contained within the overall policy manual. All of this required review by the local management or the hospital policy and procedures committee.

The policy for ordering, prescribing, storing and administration of medicines was dated 1996 and was reasonably comprehensive. The legibility of individual prescriptions was

reasonably satisfactory. Prescriptions at Ward 9 were all up to date and very clearly written. Some prescriptions at Ward 8 required re-writing and some cards in all of the long-stay wards required review and re-writing. It was noted that one patient prescribed anti-convulsants in 1999 appeared to have had no review of prescribed medicines since that date. Some drug prescription cards contained a greater number of discontinued prescriptions than current prescriptions. There was a serious risk of drug error in this practice and these cards should be re-written. Not all prescriptions contained the signature of the prescriber in full and not all were dated individually. There was provision for the recording of drug allergies in the prescription cards so that information was rapidly available to staff.

A number of clinical files were examined as part of this inspection and the overall standard was quite variable. Written instructions on filing of documentation within the medical record was required. Efforts should be made to ensure that no loose clinical material was filed in the back of each file, as the risks associated with the storage of this material in this fashion include delays in accessing pertinent information, and lost or misfiled information. There was provision for the recording of the patient's name on each continuation page, but this was not always recorded. While the date of each entry was clearly recorded, the time of entry should be recorded and all entries should contain the signature in full of the professional staff member making the entry. The nursing records examined across the hospital service were also of a variable standard. Attempts were made to use a nurse care planning system in the acute areas, and in most of the long-stay areas nurse care planning had fallen into disuse and basic nursing notes were recorded, with infrequent entries in some areas. It is recommended that the nursing records be audited to assess standards of record keeping and identify areas for improvement and staff development. Infrequent entries in the nursing notes were particularly noted in Ward 3 and Ward 8. Nursing staff of this service participated in on-going in-service training organised by the Nursing Development Unit of the WHB. Staff attending these courses were released from duty and were replaced by other nurses on overtime. There appeared to be no input from senior nurse-managers or senior clinicians of the mental health service to the content of these courses, and their appropriateness to the needs of the job required at St Brigid's Hospital or the needs of the patients and staff working there was questionable.

Access to fresh air should be regarded as a basic human need and taken very seriously by hospital service providers. In one unit at St Brigid's in particular access to fresh air remained a problem. The service providers should agree and monitor specific standards for access to fresh air for all patients.

Management should closely monitor the handling and outcome of all complaints to ensure minimum delay in complaint handling and note any quality implications arising from the complaint.

Three patients were interviewed in the admission unit in order to ascertain their views on the quality of care provided. Two patients were generally satisfied with the admission process and reported that within a reasonable time after admission they were introduced to the professional team responsible for their care, and that they were shown around the admission ward. One patient was not satisfied with the admission process, nor with the

courtesy and helpfulness of staff. He was aware of the name of his consultant psychiatrist and reported having access to the consultant once weekly. All patients reported being introduced to their primary nurse on admission. Patients reported that they were not allowed wear their day clothes following admission, remaining in night attire for up to four days. Patients were not given any explanation as to why they were not allowed wear their ordinary day clothes. Patients were not offered an information booklet about the hospital and its services and none were aware of or given access to information about their rights under the Mental Treatment Act, 1945 or the local hospital complaints procedures.

Patients were generally satisfied with the variety of smoking and non-smoking areas in the admission unit and reported general satisfaction with the sleeping arrangements and the bathroom and toilet facilities. One patient expressed dissatisfaction with the quality and quantity of food provided. The other two patients were satisfied. One suggested some improvement in the seating arrangements in the dining area. Two patients were very satisfied with the service provided by their consultant psychiatrist. Patients reported a lack of interesting and beneficial activities in the evening time and especially at weekends and on days when the OT department was closed. Patients were generally satisfied that the service provided adequate facilities to meet religious and spiritual needs. When asked if they felt there was adequate respect for privacy when being given information about treatment or advice, one patient reported satisfaction and two were dissatisfied. Some patients reported that they had not been given reasonable information about the nature of their medical condition. All reported that they were on prescribed medication, which was taken orally. Patients reported that they had received no explanation relating to prescribed medication and its potential short- or long-term effects. While patients were aware that a nurse had been assigned with primary responsibility for their care, none of the patients interviewed were aware that they had a nursing care plan. Two patients reported having adequate contact with nursing staff while hospitalised and that nurses took time to listen to their anxieties and queries. One patient reported poor contact between patients and nurses. When asked what improvements they would like to see in service provision, all patients reported the need for increased weekend activities to reduce boredom. One patient suggested that additional library books be provided in the admission area.

RECOMMENDATIONS

It is recommended that:—

1. A management project team to establish and implement policy on the future of St Brigid’s Hospital be put in place. This was the key recommendation in the Inspector’s reports for the years 1999, 2000 and 2001, and we are obliged to repeat it again this year.
2. Discussion on the provision of an acute psychiatric unit at Portiuncula Hospital should proceed.
3. Unit 1 be closed as a matter of urgency and physical conditions in the remaining units be brought to an acceptable standard.
4. A multi-disciplinary rehabilitation team be established immediately and appropriate rehabilitation inputs developed for all patients requiring this level of care.
5. The wards in the New Building be de-designated.

INSPECTED ON 21 AUGUST, 2002

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 forty-three bed acute psychiatric unit, University College Hospital, Galway (UCHG), which had one male, one female and one integrated unit. There was one integrated rehabilitation unit (9A) which had thirty beds.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	1	17	16	3	3	40	95.0
3 to 12 Months	—	—	1	—	—	—	1	2.5
1 to 5 Years	—	—	1	—	—	—	1	2.5
Over 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	1	19	16	3	3	42	100
% of Total	—	2.5	45.5	38.0	7.0	7.0	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
2	10	—	18	3	2
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
3	2	—	—	2	42

Status of In-Patients on the date of inspection 2002

Status	Male	Female	Total
Voluntary	32	22	54
Temporary	9	7	16
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	41	29	70

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
834	8.34	n/a	n/a	87.8	12.2	821	1

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of Persons Attending
Day Hospitals	1	20	186
Day Centres	4	134	124
Out-patient clinics	7	445*	5,322

*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
6	28	4	25	1	7

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
12	15	93	17	15.5

COST

The cost of the West Galway Mental Health Service was €7.6 million in 2001.

GENERAL COMMENTS

Little had changed in this service since the 2001 inspection. Certain advances projected in 2001 had not, in fact, taken place. Thus, the provision of a six-bed acute observation unit in the psychiatric unit at University College Hospital, Galway (UCHG), had not taken place. Neither had any specific accommodation been provided for acute assessment purposes for the newly established service for later-life psychiatry, although the consultant post for this service had been established. Plans to open the newly acquired Acorn House as a day centre replacement for the unsatisfactory Halla Padraig were abandoned because planning permission to use the premises for this purpose was refused on head of continuous objections by local residents. However, it was intended, apparently, to use this house to accommodate some of the current residents of Unit 9A, Merlin Park Hospital. A further setback to development had been the delay in the provision of a community-based residence in Carraroe. This was a joint endeavour between the Health Board and the local Voluntary Group. On a positive note, it was understood that the provision of a community residence and adjoining day centre at Clifden, through the initiative of a local voluntary organisation, was progressing satisfactorily.

Given the nature of the West Galway catchment area, with the concentration of population in Galway City and the dispersion of the remainder westwards throughout a considerable and sparsely populated area, made rational sectorisation or the putting in place of assertive out-reach programmes of care delivery difficult. It was understood that there was a clear plan in relation to the services in West Galway and Galway City. This included the construction of a high observation six-bedded psychiatric unit, the construction of day hospital and sector headquarters in conjunction with the St Columbus Credit Union at Ballybane and the relocation of the current day hospital to the Ballybane facility, and the setting up of an outpatient facility at the current day hospital, to include a depot Clozaril clinic and community mental health nursing component. Halla Padraig continued to offer a day centre service in quite unsatisfactory surroundings, as highlighted in report after report, year after year. The intended rehabilitation function of Unit 9A at Merlin Park Hospital had long ago fizzled out because of the lack of a specialised rehabilitation team and, perhaps more importantly, because of the absence of community-based residential places to transfer patients to. Given that one half, or perhaps even three-quarters, of the residents in Unit 9A were probably fit to move without further inputs to community residential living, the Inspectorate found it incongruous to continue their status as psychiatric in-patients in what was effectively a psychiatric unit, with their being retained on the psychiatric register. The Inspectorate had pleaded repetitively that Unit 9A be de-designated and identified as a high-support residence, which, in practical terms, it was. The practice of using the unit to 'lodge' or 'sleep-out' patients from the acute unit should be discontinued forthwith.

Apart from glazing the two nurses' stations, in Section A (male) and Section B (female), there had been no improvements to the dilapidated state of the acute unit. Externally and internally, the unit presented a shabby appearance. This was compounded, externally, by the nature of the surrounding ground areas, redolent with weeds and rubble. Internally, a roof that leaked in places, a loose window-frame and decaying woodwork, had been problems for quite some time and were still unremedied. There were other physical problems with the unit, which have been mentioned in the body of this report. The Inspectorate was told that, as part of a major development of UCHG, a new psychiatric unit was to be provided. It was unclear whether the promise of this distant Utopia was the basis for the neglect of the existing unit but, if so, the Inspectorate would urge that this attitude be reconsidered and remedial action be taken to bring the existing unit up to a satisfactory level of suitability.

It was difficult to understand why the number of acute beds for the catchment area, forty-two for a population of 100,000, was inadequate, necessitating the sending of patients to St Brigid's Hospital in Ballinasloe or to Unit 9A. The former practice, once of considerable frequency, had diminished in recent years and should be abolished altogether. It was confounded by direct transfer of patients from the catchment area to St Brigid's, completely bypassing the unit. These transfers consisted, for the most part, of PUM patients brought directly to St Brigid's by the Gardaí. The Western Health Board, together with the Department of Health and Children, should investigate the possibility of designating the psychiatric unit in West Galway as a District Mental Hospital, following the recent successful initiative of this kind in Kerry. The current practice of transferring patients

already admitted to the acute unit to Unit 9A ‘to make a vacancy’ should cease. Apart altogether from the disruption that this caused to patients on a personal basis, the manner in which it was effected was highly disturbing. The Inspectorate learned that selection of patients for transfer, often at short notice and late in the day, was made by relatively junior, and sometimes inexperienced, personnel. The manner of conveyance, unaccompanied, in a taxi, and without any clinical documentation, was dangerous and, in the Inspectorate’s view, a very serious matter. The Inspectorate was given to understand that no note, not even one indicating the medication the transferred patient might have received in the unit, accompanied him or her.

The ‘pressure on beds’ (exemplified by an unacceptably high admission rate of 8 per 1,000 of population) arose from the absence of an assertive outreach approach to service delivery and the lack of the necessary physical and human resources to accompany it. Accordingly, there was little by way of filtering or triage in place. It appeared that from 9 a.m. to 5 p.m. on a five-day week basis all patients self-referred or otherwise were seen at the psychiatric unit. Between 5 p.m. and 9 a.m. and at weekends, all patients were referred through the accident and emergency department. For security reasons, as a general principle, all patients at all times arriving for assessment should come to the A & E Department, rather than directly to the unit. Recruitment of a triage psychiatric nurse, established in some other services with funding from the National Suicide Review Group or other like body, should be pursued, as should the recruitment of a liaison registrar reporting to a designated consultant. The Inspectorate was aware that Galway city had a large number of students during term time and of tourists, particularly during summer, some of whom presented with acute problems not requiring hospitalisation, but palliative, community-based interventions. The service as currently set up did not allow appropriate discrimination as to need in the various levels of input, which was why a system of filtering and referral to appropriate agencies was required. This problem of a floating population was not unique to Galway; it impinged also on a number of other services. Another important issue bearing on the use of beds was the apparent lack of forethought and provision in relation to the continuing care requirements of the embryonic later-life psychiatry service. There was a centralised Clozaril clinic for Galway City operating from the unit, but maintained by primary care in west county Galway. The Inspectorate wondered why primary care in Galway City could not emulate its country cousin in this regard.

The Inspector’s report of 2001 commented in detail on the deficiencies in clinical documentation in the acute unit. Without repeating them in detail this year, the Inspectorate would instance an example that typified matters, namely, that the top sheet contained no section or box for indicating the legal status of patients, nor for showing an ICD diagnosis. It was noticed at the time of inspection that the door of the clinic room containing patients’ case notes remained open and, although within vision of the nurses’ station, no member of staff was within sight. Accordingly, patients, or any other person, could gain access to the confidential information contained in these case notes. It was noted that there were many ‘out-patients’ awaiting consultation in the unit and the Inspectorate was reminded once again of how unsatisfactory it was to have out-patients coming to be seen in an in-patient unit. The staff acknowledged this and, apparently, had sought accommodation in

the general hospital out-patient unit but had failed to be accommodated. In the Inspectorate's view, it would be better if out-patients were seen in primary care settings based close to their homes, which would encourage and stimulate integration of psychiatric with primary care services, and their personnel.

The written drugs policy and procedure was last reviewed in 1992 and needed to be updated. This was highlighted in the 2001 report. A number of prescription cards were examined. For the most part, the legibility of individual prescriptions was generally satisfactory. However, it was noted that a small number of scripted prescriptions were difficult to read. Written instructions for use of prescription cards was required and should be incorporated into the revised procedure and policy. While all prescriptions were signed and dated individually and changes in prescriptions were written as new prescriptions, there was a need for the full signature of the person prescribing to facilitate easier identification of the practitioner in the future. There was provision for the recording of drug sensitivities so that information was rapidly available to staff. The drug administration recording card should have provision for the nurse's signature in full.

The nursing records examined were kept up-to-date and were generally written clearly and dated accurately. The time of entry should be recorded and all entries in the nursing records should be signed in full. Entries made by student nurses should be counter-signed by the appropriate primary nurse. It was suggested that the nursing records be audited to assess standard of record keeping and identify areas for improvement and staff development. Nursing records should reflect the involvement of patients in planning and making choices and decisions about their care and treatment. Similarly, nursing evaluations should include the patient's views about progress. All records should be in black ink so that they are readable in photocopied form.

Thirty-three patients were prescribed ECT at University College Hospital Galway in 2001. The facilities for ECT comprised waiting, treatment and recovery areas and were of a very high standard. The nursing preparation checklist should be reviewed and updated to include a pre- and post-ECT treatment checklist. This was also highlighted in the Inspector's Report of 2001. There were nineteen complaints and twelve Freedom of Information Act requests made to the local complaints appeals manager during 2001 and all appeared to have been dealt with satisfactorily. There were eighty-five involuntary admissions to the service in 2001. Involuntary admission forms examined were completed satisfactorily. Forty-three patients were placed on one-nurse-to-one-patient special nursing supervision, involving 725 duty spans of ten hours or more. The policy and procedure relating to special nursing supervision and prescribed recorded observation was under review at the time of this inspection. There were fifty-three recorded accidents to patients and four recorded accidents to staff. Twenty-two of the accidents to patients resulted in minor injuries, scratches and bruises, and none was deemed serious. There were two recorded assaults on patients by other patients and seventeen recorded assaults on staff. Seven of the staff assaults resulted in minor injuries, scratching and bruising, and none was deemed serious. A poor photocopy of the WHB generic safety statement was available in the ward areas. This was unsigned and undated. There was no evidence of recent safety audits, or when they were last completed. Site-specific safety statements should be available in each local

unit, adhering to the standards and procedures set by the Safety and Welfare at Work Act 1989. The safety statements should identify the safety committee and the identifiable safety officer. Hazard control sheets and results of safety audits and actions taken to rectify identified hazards should be available in each local area. These should be reviewed annually by the hospital management committee. There was a personal safety alarm for staff at University College Hospital Galway, but no written policy was available for staff information and reference. The service should consider the installation of a more extensive safety alarm to cover the entire unit, particularly the areas where staff worked in isolation from the nursing stations.

The policy and procedure manual was dated 1995 and required review and updating. As mentioned in the 2001 Inspector's Report, the following issues should be considered for inclusion in the hospital policy and procedure manual: access to health records; accidents and incidents; handling and lifting policy and procedure; hepatitis B vaccination; informing patients of their rights; panic alert; management of patients' money and handling of personal property; patients voting rights; personal searches of patients and their belongings. The service should also consider issuing guidance on the management of illicit-drug-related incidents. Such guidance should clearly set out expected actions where there was suspicion of illicit drug use or supply, whether by patients or visitors, powers of staff to search for and confiscate illicit drugs, information on powers of staff to handle and dispose of illicit drugs that came into their possession, and expected arrangements with the Gardaí over issues relating to illicit drugs. It was essential that hospital staff were provided with effective policy guidance on what action they can or should take when they suspect or know of substance misuse. These policies should be linked with the hospital's health and safety policy.

All patients, irrespective of their status, must be informed of their rights. Voluntary patients should be told, if they wished to leave hospital, that this must be discussed with their consultant or, in his or her absence, with the nurse in charge. The rights of detained patients should be prominently displayed in in-patient care areas and included in the hospital brochure. Informing patients of their rights included two tasks: the first was to provide written explanation via patient leaflets or hospital notice boards, the second was to be satisfied that the patient understood his or her rights. Entries should be made in the patient's nursing notes showing that an oral and written explanation had been given, with an indication of the patient's comprehension. Service providers were working on the production of a hospital brochure with pertinent information relating to a patient's stay in hospital, and including information on complaints procedure and patients' rights. Once there was general agreement on the content of the brochure, copies would be printed and made available for the information of patients and visitors. Notices on hospital charges for in-patients were prominently displayed at the acute in-patient unit. The patients' money-management systems appeared satisfactory and the Inspectorate was informed that these were audited on a yearly basis. A written report on the auditing process, findings and recommendations should be kept.

Two patients were interviewed to assess consumer opinion as to the psychiatric services provided. One patient was of temporary status and the second was voluntary. Both were

quite pleased with the admitting procedures and were introduced to the care staff immediately on admission. The primary nurse arrangement seemed to operate intermittently, as some days nurses introduced themselves as being the relevant primary nurse. Both knew their consultant psychiatrist and they had consultations with them about two to three times weekly. Both patients said it was the custom not to be allowed to wear their own clothes for some days after admission. The temporary patient was actually in his pyjamas at the time of interview, despite the fact that he had been some months in the hospital. There was obviously some clinical reason for his being in his pyjamas; he was in no way bothered by this and added that he was in ‘the high-risk’ area of the unit. Both patients were quite pleased with their therapeutic teams, but one patient said he would appreciate more one-to-one consultations with his doctor in the absence of the other team members. Neither patient had been offered an information booklet, but it was later discovered that a new, updated version of the patient booklet was currently being printed. Both patients were pleased with the courtesy and dignity afforded them at all times. They were also pleased generally with the ambience and décor of the unit, but had major reservations about the toilet facilities. One patient would appreciate more in-depth knowledge of the medications prescribed and would particularly like written information. Neither patient had been involved in decisions concerning their own care, nor were they aware of the existence of care plans. Neither patient had had a consultation with a psychologist or a social worker. When asked for their suggestions for the improvement of the services provided, one said he would like more intimate involvement with the consultant regarding diagnosis and treatment and would particularly like to be involved in a care plan, while the other concentrated mainly on the recreational and social activities that he found lacking. The latter would like access to gym facilities, football, etc. He was very pleased with the relaxation therapy and would appreciate more sessions of same, and would like if meditation and yoga were introduced.

RECOMMENDATIONS

It is recommended that:—

1. Extended physical community provision be put in place in this service, including a day hospital at Ballybane and the use of Acorn House as a community residential centre.
2. The psychiatric unit at University College Hospital Galway be designated as a District Mental Hospital, enabling it to deal in a self-contained fashion with all the in-patient needs of its catchment area without recourse to St Brigid’s Hospital, Ballinasloe.
3. An acute observation area within the psychiatric unit at University College Hospital Galway be established as planned.
4. A new unit for the acute assessment of the newly established later-life psychiatry service be provided as well as the exploration of the provision of continuing care facilities for this service.
5. A triage system be set up, based on the accident and emergency department, to implement an appropriate referral policy.

6. The acute psychiatric unit at University College Hospital Galway be refurbished and redecorated as a matter of urgency.
7. Unit 9A be de-designated and recognised as a high-support residence with the immediate phasing out of its use as a ‘sleeping-out’ facility.
8. A specialised rehabilitation team be established to work conjointly with rehabilitation agencies, such as the quality Unit 10 endeavour, and community-based residences be sought out and provided for patients such as those currently in Unit 9A, to enable that premises to be used as an active and vigorous rehabilitation facility — the purpose for which it was originally intended and funded.
9. A revised drugs policy and procedure should be drawn up.
10. The policy and procedure manual be updated, with an appropriate review date.
11. Personal safety alarms be made available to all staff working at the acute psychiatric unit.

MAYO MENTAL HEALTH SERVICE — 2002 INSPECTION
INSPECTED ON 18 AND 19 SEPTEMBER, 2002

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 111,000 was divided into five sectors as follows:

Sector	Population
Castlebar	13,000
Ballina	25,000
Westport	25,000
Swinford/Claremorris/Kiltimagh	26,000
Achill/Belmullet	22,000

IN-PATIENT CARE

In-patient care was provided at St Mary’s Hospital, Castlebar, which had 138 beds in three male, two female and two integrated units.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	1	11	13	3	—	28	20.29
3 to 12 Months	—	—	4	9	1	—	14	10.14
1 to 5 Years	—	—	6	4	2	—	12	8.70
Over 5 Years	—	—	3	27	24	30	84	60.87
All Lengths of Stay	—	1	24	53	30	30	138	100
% of Total	—	0.72	17.39	38.41	21.74	21.74	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
2	64	6	21	16	1
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
5	9	—	14	—	138

Status of In-Patients on the date of inspection 2002

Status	Male	Female	Total
Voluntary	69	40	109
Temporary	12	10	22
P.U.M.	1	—	1
Ward of Court	—	3	3
Total	82	53	135

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
664	6.0	148	22.3	87.7	12.3	692	4

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of Persons Attending
Day Hospitals	2	45	146
Day Centres	6	83	329
Out-patient clinics	10	239*	942

*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
13	59	6	43	2	18

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
12	30.10	243.61	115.39	4

COST

The cost of the Mayo Mental Health Service was €15.3 million in 2001.

GENERAL COMMENTS

These were exciting times in the Mayo Mental Health Service as it worked towards the closure of St Mary's Hospital. The psychiatric unit in Castlebar General Hospital was now in the possession of the mental health services and negotiations concerning 'movement money' between the nursing union and the management were at an advanced stage. The current date for opening the unit was given as 16 November 2002. Once this happened, St Teresa's unit on the St Mary's campus would close for refurbishment in preparation for its new role as a 'continuing care' unit. In fact, with the transfer to it of patients from the long-stay wards in St Mary's three-quarters of whom were aged seventy years or over, it would become a unit for older persons. The plan, however, was for St Teresa's Unit to become a continuing care unit that was a part of the rehabilitation service and not part of services for older people. At St Mary's, the intensive care unit would transfer its patients to the new high-support residence, called Ashling House, which was now ready to receive them. Once the long-stay patients from St Mary's were transferred to the refurbished St Teresa's and two intellectually disabled persons currently in St Mary's were transferred to Aras Attracta, St Mary's could close. The vacated space would be taken over by the educational authority, which already occupied a substantial portion of St Mary's. It was important that Ashling House adopted an active rehabilitation role and it was the Inspectorate view that the Mayo service should establish a specialised rehabilitation team to provide active rehabilitation, not just in Ashling House but on an outreach basis to the rest of the service, including the many persons in need of such inputs in the sectors, the residences and day centres.

A new sector headquarters was to be provided in Claremorris for Sector 4. In this sector, the O'Hara Home premises in Kiltimagh and the other residential facilities in the town had been satisfactorily upgraded and were now functioning well, the Inspectorate was told. There was a good deal of overcrowding in the high-support residence at Swinford, which was not helped by allowing day patients attend there, many of whom crowded the kitchen (there was no separate dining facility) at mealtimes. Equally unsatisfactory was the holding of out-patient clinics there once a week. It would be far better were an independent premises obtained for day centre purposes or, as the Inspectorate was told might be the case, this activity might be based in Claremorris. Likewise, the out-patient clinics would be better held at the Swinford generic health centre.

In Ballina, the former district hospital premises now served a multiplicity of functions; it comprised a high-support residence, a distribution and medication centre for day patients, a partial sector headquarters including an outreach component, a day hospital, and a venue for out-patient clinics. The day hospital activity was limited to dealing with minor illnesses and maladjustments and it did not function as an acute day hospital dealing with more severe illnesses. The plan was to provide, on the day hospital premises, a rehabilitation unit for female patients only as the premises would sleep in one space four patients of the same gender. The intention was that the candidates for this programme be recruited from the existing day centre attendees, most of whom came from group homes, with a

view to training them for independent community living. It was the opinion of the Inspectorate that some rationalisation of the activities carried out from this premises should be undertaken. It was felt that the out-patient clinics should be held elsewhere and that serious consideration be given to creating an acute day hospital activity here in Ballina, either in this premises or elsewhere. Apart from other reasons and as a matter of principle, the reduced number of admission beds in the new psychiatric unit would mean that an acute day hospital operation would reduce the need for in-patient admission. The three group homes which had opened in Ballina quite recently were visited and were found to be in satisfactory condition. A fourth home was due to open shortly. The residents of these homes, as well as other persons, attended the active training centre, with its variety of operations, which the Inspectorate enthused over in 2001.

In Castlebar there was a compelling requirement for a new, active, acute day hospital and a day centre operation or alternative. This latter was proposed because of the extraordinary practice of admitting persons from the Castlebar sector to St Teresa's on a weekend basis. This had led to an admission rate for this sector of almost 16 per 1,000 of population — by far the highest in the country. Those presenting to St Teresa's for admission were not from group homes but from independent accommodation. The Inspectorate was at a loss to understand why the Castlebar sector should be unique, nationally, in this regard. At any rate, some remedial action was obviously essential, the more so with the need to use the reduced number of beds in the new Castlebar Hospital Psychiatric Unit for truly acute purposes. A sector/catchment area headquarters would be required in Castlebar and needed to be provided.

As already alluded to, the day hospital element of the Mayo service needed to be strengthened, with a stronger senior medical presence and an increase in the existing psychology, occupational therapy and social work personnel. The generous nurse staffing of this service should lead to more skilling and innovative deployment of staff on a community basis.

Finally, the Inspectorate would like to compliment the Mayo service on the generally satisfactory standard of patient provision and care in five of the St Mary's Hospital wards, much of which had taken place in the past couple of years. It was gratifying to see at least one service where the knowledge that patients would shortly be moving had not interfered with current standards of furnishing and decoration. The intensive care unit is excluded from this eulogy — but then, it too was due to move.

The specialised service for the psychiatry of later life would shortly be operating, with the arrival of the newly appointed consultant to this team. It was the view of the Inspectorate that a further specialised team for rehabilitation was also necessary.

There were 1,210 spans of special nursing supervision involving twenty-eight patients in this service in 2001. Statistical information relating to episodes of seclusion in 2001 was not available. Ten patients in St Teresa's unit were prescribed ECT in the same year. There were 664 admissions to the service, of which 148 were first-time admissions. There were eighty involuntary admissions and two patients admitted on PUM forms in 2001. Twenty-four patients admitted as voluntary patients were regraded to involuntary, and

thirty-four patients admitted as involuntary patients were regraded to voluntary during the course of their hospitalisation. Statistical data relating to the extension of involuntary admission forms was not available. There were four deaths in St Mary's Hospital and twenty-one patients took their own discharge from the hospital against medical advice. Follow up procedures were in place for those patients if deemed clinically appropriate. There were nine requests made for information under the Freedom of Information Act during 2001 and all appeared to have been dealt with satisfactorily. There were no recorded complaints made to the local complaints manager during the year. There were no research projects undertaken in this service governed by the Clinical Trials Act 1987 — 1990. Thirty-nine accidents to patients and fourteen accidents to staff were recorded in the service in 2001. Two of the staff accidents and one of the patient accidents required further medical intervention. Of the fifty-three assaults on patients by other patients and the ninety-two assaults on staff, two of the staff assaults were deemed serious, fourteen of the staff assaults and fifteen of the patient assaults resulted in minor injury, such as scratches or bruising. It was noted that the numbers of assaults on patients and staff had almost doubled since the previous year and it was suggested that the service critically examine this area to determine cause of assault and an analysis of assaults by date, time and location. The service should develop a definition of 'at risk' and 'dangerousness' to which all staff should adhere. A psychiatric clinical risk assessment screening tool should be developed, to include identification of any current risk factors, plus any past history of a patient causing harm to himself or to others, or of anti-social behaviour. An element of patient self-assessment should also be considered.

The written drugs policy and procedure for the ordering, prescribing, storing and administering of medicines was under review. A number of prescription cards and drug administration cards were examined. Individual prescriptions were legible, but a small number were difficult to read. Prescriptions were signed and dated individually. Some of the signatures of prescribers were illegible. Generally, discontinued drugs were signed off using the discontinuation column, but this was not the case in all areas of St Mary's Hospital. On a number of prescription cards examined, the number of discontinued prescriptions exceeded the number of current prescriptions. These should be rewritten as they posed an increased risk of error of administration. The storage area and transport facilities between units was satisfactory. There was a need for written instructions for the use of prescription cards. The drug administration recording card had provision for the nurse's signature in full and this should always be recorded. It was noted that some cards were unsigned.

Each newly admitted patient to St Teresa's unit had a full medical evaluation, including comprehensive admission notes, mental state examination, physical examination and clear immediate management plan, all appropriately recorded. There was provision for the recording of the patient's name on each continuation page, but this was not always recorded. Written instructions on filing of documentation within the record was required. Some inputs in the clinical notes were unsigned and this required attention. Designation of the doctor obtaining the information should be recorded. This would enable identification of the practitioner in the future.

While there were no formal complaints made to the local complaints/appeals manager in 2001, management should closely monitor the handling and outcome of all informal complaints to ensure minimum delay and note any quality implications arising. There was no notice informing patients of their rights and notices relating to the complaints procedure were not prominently displayed. There was no hospital brochure with pertinent information relating to a patient's stay in hospital. 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, with the clinical nurse manager. The rights of detained patients should be prominently displayed in in-patient care areas and included in the hospital brochure. Informing patients of their rights comprised two tasks: the first was to provide written explanation via patient leaflets or hospital notice boards; the second was to be satisfied that the patient understood his or her rights. Upon admission, or as soon as practicable thereafter, patients must be informed of their rights. An entry should be made in the patient's nursing documentation that an oral and written explanation had been given, with an indication of the patient's comprehension. If the patient was clearly incapable of understanding his or her rights, this should be recorded and the information should be repeated at regular intervals, using professional judgement to decide the patient's capacity for understanding.

The arrangements for ECT were all satisfactory. There was a dedicated ECT suite comprising three or more rooms, including separate waiting and recovery areas. A named consultant was responsible for the ECT clinic and there was appropriate induction for new doctors. The consent form in use was satisfactory. A pre- and post-ECT nursing checklist should be introduced.

A written safety statement adhering to the standards set by the Safety and Welfare at Work Act 1989 was available, but this statement was dated 1993 and required review. Copies of hazard-control sheets indicating period safety audits should be available in each location, indicating identified hazards and giving the name of the person responsible for addressing these. The service had a policy, dated 1 February 2000, relating to patients absent from the hospital without official leave. The policy set out who was to take charge of the procedure once a patient was deemed absent without official leave. The policy required review and should include information on how a local search was organised, the name of the person to contact the Gardai, and when to contact the Gardai, and when and who should contact the patient's relatives. The policy should also include information relating to the service's responsibility to return patients. There was a weekly meeting with patients at St Teresa's unit that included time for seeking feedback from patients and families on service provision. Reports relating to this feedback should be included in an annual review of service provision.

There was no formal risk management group or forum within the mental health services in Mayo. Managers should consider constituting a formal multi-disciplinary group, working to agreed terms of reference, to develop a risk-management strategy to encompass both clinical and non-clinical issues. A senior member of staff should be designated to act as co-ordinator for activities arising from this strategy and to provide advice to staff. A

rolling programme of clinical and non-clinical risk assessment should be developed and implemented.

Generally, staff appeared aware of the importance of approved policies and procedures. At the time of the inspection, a committee had drawn up a list of available policy documentation. Several policies, procedures and protocols were in place. The content was generally found to be detailed and unambiguous. Policies and procedures generally should relate to the care of patients. General health board policies relating to staffing issues, e.g., sick leave regulations, should be stored in separate folders from the clinical policies and procedures and protocols, which should have a multi-disciplinary focus, be headed with the unit title, be individually numbered and record the date of ratification, with an appropriate review date and audit date, and detail responsibility for these. There should be a computerised index of all policy documentation, which records dates of ratification, implementation and review. Each policy file should be indexed, with responsibility identified for insuring the file was updated. Revised and superseded policies should be removed from operation, and a pre-determined number of copies retained centrally for possible reference in the future. No draft policy should be placed in operational policy files. Policies should be formally introduced to all relevant staff, ensuring awareness and understanding of content. Staff should sign to say they have read, understood and intended to and were able to comply with the policy content. All of this work was required prior to or post relocation to the acute unit, Castlebar General Hospital.

A number of patients in St Teresa's admission unit were interviewed to ascertain their views on the level of service provided. Generally speaking, patients were satisfied with the admission process and with the courtesy and helpfulness of staff. One patient was unhappy with the admission process and reported not being introduced to the professional team or shown around the ward on admission or within a reasonable time thereafter. All patients were aware of the name of their consultant psychiatrists and reported having reasonable access to them while hospitalised. Patients reported that, post admission, they were allowed wear their own clothes. Patients were not offered an information booklet about the hospital or its services or made aware of their rights under the Mental Treatment Act, 1945 or of the local complaints procedure. All patients reported that it was possible to get refreshments when needed and all felt safe as in-patients in the ward. Patients were generally satisfied with the variety of smoking and non-smoking areas, with the heating and overall cleanliness of the facilities. All were satisfied with the services provided by the consultant psychiatrists and all reported receiving reasonable information about the nature of their medical condition, including medication and treatment. All patients were taking prescribed medications and reported that the medical staff discussed medication levels and possible effects and side-effects with them prior to taking the medication. All patients reported that they had been actively involved with the medical staff in relation to all decisions affecting their care. Patients were not aware if there was a primary nurse responsible for their care or if they had a nursing care plan. All reported adequate access to nursing staff who listened to their anxieties and queries about treatment and made reasonable efforts to answer them. Patients interviewed had not seen a social worker. One patient felt there was insufficient information available to them about social welfare benefits. None of the patients interviewed had seen a psychologist. All patients were satisfied

with the activity programme, which provided a range of high-quality therapeutic interventions which patients found helpful. Some patients reported that the day was long and boring at weekends when the activity programmes were not functional.

RECOMMENDATIONS

It is recommended that:—

1. The acute in-patient services transfer from St Teresa’s Unit to Castlebar General Hospital as soon as possible.
2. The need for acute day hospitals in the sectors be addressed.
3. A specialised rehabilitation team be put in place.
4. Personalised night attire be provided for the patients in the long-stay wards of St Mary’s Hospital.

ROSCOMMON MENTAL HEALTH SERVICE — 2002 INSPECTION

INSPECTED ON 12 JULY, 2002

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 thirty-bed acute psychiatric unit in Roscommon General Hospital.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	—	4	3	—	1	8	100
3 to 12 Months	—	—	—	—	—	—	—	—
1 to 5 Years	—	—	—	—	—	—	—	—
Over 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	—	4	3	—	1	8	100
% of Total	—	—	50.0	37.5	—	12.5	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	3	—	2	—	—
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
—	3	—	—	—	8

Status of In-Patients on the date of inspection 2002

Status	Male	Female	Total
Voluntary	9	6	15
Temporary	3	2	5
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	12	8	20

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate*	No.	% of all	Voluntary	non-voluntary		
449	8.5	118	26.3	88.9	11.1	443	1

*Per 1,000 population

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of Persons Attending
Day Hospitals	1	10	437
Day Centres	6	153	254
Out-patient clinics	7	229*	614

*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	7	5	45	1	15

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
10	15	112	76	7.25

COST

The cost of the Roscommon Mental Health Service was €10.2 million in 2001.

GENERAL COMMENTS

There had been few changes in the Roscommon service since the inspection of 2001. However, a house had been purchased in Roscommon town to provide for a day hospital operation independently of the unsatisfactory and very small operation currently in the psychiatric unit in Roscommon General Hospital. Moving the day hospital from the unit to this house would be a major step forward for the Roscommon sector. Because of the limited space available in it and the absence of any space of sufficient size, the Inspectorate would have some reservations about its capacity to deal with quite ill patients. However, the team acknowledged this constraint and was committed to providing a purpose-built premises on land owned by the board in Roscommon in the longer term. Unfortunately, a plan to provide a day hospital in a premises in Athlone town, which was planned in 2001, had not materialised. Finally, in the Roscommon sector, a house had been identified as suitable for a high-support/rehabilitation residence but, unfortunately, the fire officer and health and safety personnel did not approve it. This had been a significant setback for the sector because of the very limited availability of houses of sufficient size for the purported function. In the Athlone sector, the absence of a day hospital was a serious deficit. Such provision had been included in the service plan for this sector.

Admission rates remained extremely high in this catchment area and, at just under nine per 1,000 population, were among the highest in the country. It was noticeable that high admission rates characterised the Roscommon and Castlerea sectors, in contrast to the Boyle sector where admission rates were substantially lower. Staff attributed this to the lack of an adequate day hospital and other community-based facilities in the former two sectors. Within the unit itself, the lack of a close-observation area was perceived as a significant drawback and had resulted in a very high rate of special nursing. The Inspectorate spent some time discussing the possibility of providing an observation area, to include both close and medium-close observation rooms and beds, with relevant staff. As a result, the Inspectorate believed that, at relatively modest cost, the unit could be redesigned to provide this requirement. It was suggested to staff that they draw up preliminary plans to this end, and that the Inspectorate would be happy to discuss the matter with them and lend support to any proposal that met with our approval. It was noted that the so-called safe room, which was of concern during the 2001 inspection, had now been upgraded and made safe — although it had not been used. Also welcomed was the fact that this unit operated an open-door policy.

Further to the high admission rate, the Inspectorate noted that approximately four of the twenty patients in the unit on the day of inspection suffered from intellectual disability, although they had had co-morbid psychiatric illness. However, it was reported that, with the lack of a specialised professional team for intellectual disability, as well as concomitant day facilities for this group with special needs, there would still be inappropriate admissions to in-patient care in the unit. It was pointed out that there was just one professional team for intellectual disability for the entire areas of Galway and Roscommon.

Although there was a formal admission policy document in the policy and procedures manual to the effect that all referrals for assessment to the unit should come via the A & E Department, in practice this did not always happen. Additionally, it seemed to be the case that junior doctors made admission decisions without consulting consultants. This, no doubt, was part cause of the high admission rate, as was the practice of admitting alcoholics for detoxification unnecessarily and inappropriately. Of course, greater day hospital availability and a greater outreach orientation to this service (relatively well staffed, particularly with nurses) would ensure that assessments took place at a community or domiciliary level, rather than in the unit.

The Naomh Chaolain premises in Castlerea provided residential care for older persons and a day/training centre facility for those residing in the sector, either in boarding out facilities or in their own homes. The residential component for older persons was put in place to cater for patients of this nature on the closure of St Patrick's Hospital, Castlerea. It now took older persons from the community and also those who had grown elderly in mental health community residential facilities. It seemed to the Inspectorate to be somewhat 'free-floating' and not integrated with the care of older persons generally in the county. In addition, there was no exclusively designated team responsible for all patients therein. It was felt that its role and function, particularly having regard to the county services for older persons, should be explored and clearly delineated. It was of note that there was no psychiatrist either with a special or exclusive interest in older persons in the service. The Inspectorate wondered whether the new appointment in East Galway might not assume responsibility for county Roscommon as well. A particular issue that needed addressing was the lack of any link between the Sacred Heart Home for older persons in Roscommon and the Naomh Chaolain unit.

Similarly to the situation with the elderly, the Inspectorate felt there was a lack of any co-ordinated approach to rehabilitation as no clinical team had exclusive responsibility for this function, in the absence of which the prioritisation of persons for residential community places, as well as for more rehabilitative effort, was muddled and unclear. In this context, it was noted that the house in Roscommon identified as a potential rehabilitation residence, had not been approved by the relevant fire and health and safety authorities.

Case note composition and structure was of reasonable standard and, in general, the admitting doctors did provide more or less adequate information on the paths to admission, although not specifying why alternative provision was deemed unsuitable. There was evidence that consultants saw patients within a reasonably short period following admission. However, care plans, both medical and nursing, with evidence of patient involvement, were not always apparent. Diagnostic formulations were generally available but ICD coded diagnoses were not recorded in case notes. Junior doctors signed temporary patient reception orders and it was not clear whether they were officially cleared to do so by the Health Board. The Inspectorate pointed out that it would prefer that all reception orders were signed by a consultant. Case notation did not give reasons why voluntary status had not been explored as an alternative to involuntary detention, nor why, following admission involuntarily, this status was deemed necessary to continue. Consultants only prescribed special (one-to-one) nursing and reviewed it on a twenty-four-hour basis. In addition to

this practice, a fifteen-minute observation system operated and documentation relating to it was generally satisfactory, although it was noted that, on occasion, prescriptions were dated and signed ‘en bloc’.

Noted on one prescription sheet was a very long list of individual drugs being administered, many of the psychotropic variety, and with overlap. It was recommended that a drug prescribing audit exercise be carried out by consultants in relation to prescribing by junior doctors. It was reported that a primary nurse allocation system existed in relation to patients, but that this was on a sector basis. Given the imbalance between patients from different sectors, the Inspectorate wondered how this operated in practice. Some staff members did not wear identification badges.

There was a satisfactory, if small, OT department staffed by two occupational therapists and an OT aide in the unit, which seemed to cater for the majority of patients. The ECT suite was satisfactory and, while documentation was adequate, there did not seem to be a dedicated ECT consultant or nurse. In relation to the latter, it was claimed that ECT was not prescribed and administered sufficiently often to justify a full-time ECT nurse.

The Roper model of nursing was in use and there was staff training on nurse care planning. It was reported that care plans were reviewed continuously but the documentation surveyed did not clearly confirm this. The patient’s primary nurse was inserted in the nursing record, it was reported. The record did not indicate the involvement of patients in care planning or in their review of progress. Attention was paid to ensuring that entries were being made as soon as possible after the events to which they related and the use of abbreviations was being phased out. As with medical entries, it was pointed out that each entry should be signed in full, with the designation of the signatory’s status, and that a formal written example of signatures be instituted and preserved for each new member of nursing and medical staff who worked on the unit.

A new hospital brochure had recently been produced and satisfactorily gave information on major items of the unit’s purpose and function. Notices of patients’ rights were on display but were not brought to the attention of individual patients on admission or during their stay. There was a complaints procedure in operation, but not displayed. Although it was said that this was brought to the attention of patients individually, one patient interviewed by the Inspectorate did not confirm that this was the case, nor was there any recording in case notes or nursing notes that this information concerning the complaints procedure and the complaints officer was notified to patients.

There was a policy and procedure in relation to patients absent without leave documented in the policy and procedures book and it was reported that it was adhered to in all cases when the need arose. Seclusion did not take place in the unit, even though the seclusion or safe room had been upgraded since the 2001 inspection.

There was a multi-disciplinary management group in place and all persons spoken to said that this membership composition was very important so that all disciplines were involved in planning and management of the services. However, the most recent meeting of this

group had taken place in March 2002 and the Inspectorate was informed that there had been particular difficulties around this time and that, prior to this, the meetings had been on a regular monthly basis and were now resuming. Both a fire committee and a safety committee operated but it was not possible to establish when they last met. There was an induction process for staff, nursing and medical, and a system for reporting and documenting accidents and assaults, although the Inspectorate did not see this documentation. Service plans were reviewed regularly but the Inspectorate was unable to establish that there was a five-year plan in operation.

There were five intellectually disabled persons in the high-support residence at Knockroe House. A relationship had been established with the specialised services of the Brothers of Charity, which would ultimately lead to these five being taken to residential accommodation provided by that service.

One patient was randomly selected for interview at the acute psychiatric unit in Roscommon. She was a middle-aged person and this was her second admission to the unit. She was indeed fulsome in her praise for the services provided her. The doctors and nurses were constantly in contact with her and she appreciated their attention. Her consultant psychiatrist saw her three times weekly and she had even more frequent access to the junior doctors and the nurses. The key nurse concept as it was usually understood was not in operation here, but each day specific, named nurses were assigned to the various consultants and patients were made aware of this each morning. This patient had had her illness and medication fully explained to her. She did experience side effects to her medications and these were also explained to her by her consultant psychiatrist and appropriate changes in drug medication were made. She was very pleased also with the food supplied and its presentation, as she was also with the entire décor of the hospital. She was not aware of her rights under mental health legislation, or of complaints procedures, but she admitted this was due to her lack of interest in either the legislation or complaints. When asked how she would like to see the services improved, she replied: ‘I couldn’t suggest anything better.’

RECOMMENDATIONS

It is recommended that:—

1. Day hospital premises be acquired in Castlerea and the house purchased for this purpose in Roscommon be brought into operation as quickly as possible.
2. Additional high-support/rehabilitation residential accommodation be acquired as part of a specialised rehabilitation, multi-disciplinary operation.
3. The approach to the care of older persons in the county, including those in Naomh Chaolain, be rationalised and provided with a specialised psychiatric input.
4. Plans be drawn up to design and provide a close-observation area within the psychiatric unit at Roscommon General Hospital.
5. A more community and domiciliary outreach orientation be brought to bear on the assessment of patients, to avoid assessment taking place in the psychiatric unit, bypassing the A & E Department and leading to the unacceptably high rate of admission to in-patient care.

CHAPTER TEN

Registered Psychiatric Hospitals

ST PATRICK’S HOSPITAL — FIRST 2002 INSPECTION

INSPECTED ON 11 APRIL, 2002

IN-PATIENT CARE

In-patient care was provided at St Patrick’s Hospital, Dublin, which had 186 beds.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	2	5	44	42	20	10	123	73
3 to 12 Months	—	—	2	3	6	4	15	9
1 to 5 Years	—	—	1	6	11	5	23	14
Over 5 Years	—	—	1	2	1	3	7	4
All Lengths of Stay	2	5	48	53	38	22	168	100
% of Total	1	3	29	31	23	13	100	

Status of In-Patients on the date of first inspection 2002

Status	Male	Female	Total
Voluntary	146	93	239
Temporary	2	2	4
P.U.M.	—	—	—
Ward of Court	2	—	2
Total	150	95	245

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate	No.	% of all	Voluntary	non-voluntary		
1,811	—	707	39.04	97.3	2.7	1,804	5

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
22	36	149	105	27

GENERAL COMMENTS

St Patrick's Hospital continued to provide private in-patient care for the entire country. Thirty beds at the hospital were subvented by the ERHA for patients from the nearby St James's Hospital. These beds provided on-going care on a semi-long-term basis for mainly older patients. In addition, a Day Care Centre for general adult psychiatry and the Martha Whiteway Day Hospital for the psychiatry of later life, both publicly funded, were provided on campus. As mentioned in previous reports, the provision of community services by St Patrick's for the nearby St James's service was an anomalous situation and the Inspectorate felt that the two services should operate independently of each other. St James's should provide and staff its own community services to complement its in-patient unit and to ensure continuity. Similarly, the provision of a day hospital for the psychiatry of later life in the grounds of St James's Hospital would be preferable to the present arrangement of having this facility located in St Patrick's Hospital.

St Patrick's Hospital itself had been extensively refurbished in recent years and this had resulted in a very high standard of patient accommodation. The attractive appearance of the wards gave a positive message about the overall care programme to patients. New link corridors connecting the Dean Swift Unit to other parts of the hospital had opened since the last inspection and most of the building work was now completed. There were 245 patients in the hospital on the day of inspection, 150 female and 95 male. Four patients were hospitalised on temporary certificates and two patients were Wards of Court. The hospital had a total of 186 beds, sub-divided into one male, two female and six integrated nursing units. Three nursing units, Emmett, Dean Swift and Sheridan, were locked units accommodating seventy-nine patients in total. Four per cent of the hospital population had been hospitalised continuously in St Patrick's for five years or more. Thirteen per cent were aged over seventy-five years and a further twenty-three per cent were aged between sixty-five and seventy-four years. A number of initiatives had taken place in this hospital since the last inspection. A new accreditation process formally commenced in January 2002 with the establishment of a quality steering committee. This steering committee will develop a quality improvement plan detailing patient-centred and hospital management standards to meet the Joint Commission International Health Care Organisation (JCI) standards. This work was very much in its infancy at the time of this visit.

A new Clinical Council consisting of the medical director, consultant medical staff, senior nursing staff and senior staff allied to medicine was established in order to discuss and resolve issues of professional relevance. This Council met on a regular basis and approved policies, guidelines and standards for the hospital. New procedures were introduced which formalised the notices patients must give of their intention to leave hospital against medical advice. Similarly, new procedures relating to the requirement of voluntary patients to give seventy-two hours notice of intention to leave hospital were introduced since the last visit of inspection. It was noted since these formalised procedures were put in place there had been a marked reduction in the number of applications from patients to leave hospital against medical advice. An information leaflet was handed to each patient on admission, giving patients written information on the name of the ward, name of senior nurse, name of designated primary nurse, names of consultant and non-consultant hospital doctors and names of other allied staff likely to be associated with a patient's care. This was piloted

in two wards at the time of this visit, with the intention of extending this welcome initiative to all wards. A 'Coping at Home' (pre-discharge) group was established for patients with multiple admissions who tended to have long stays in hospital or for patients who were fearful about returning home. The group explored issues and fears surrounding discharge, goals were set for patients while on weekend leave and reviewed on return from leave. Each session lasted approximately one hour and patients were encouraged to attend six sessions in total. A new 'Buddies Group' for men living alone (widowers, separated and single men) was established in order to respond to the problem of male suicide. This group was not well attended but it was expected that it would evolve over time. A new Consumer Council had met three times since it was established and was proposing to visit the hospital. This Council was very much in its infancy. A revised, formalised medical care plan had been introduced on a pilot basis. This was under review at the time of our visit with a view to extending the plan to all areas. It was intended to have a summary of patients' treatment in hospital during the end of their stay in the front of each file.

There had been some nurse shortages in St Patrick's, with twenty-five vacancies on the day of inspection. Recruitment of qualified staff remained a major challenge similar to other services within the ERHA. However, the hospital had had some success in recruiting staff from abroad. It was intended to introduce care staff and ward clerks to the ward areas. This revised skill mix would ensure that St Patrick's had an adequate supply of personnel to ensure continuity and appropriate care for patients.

Two hundred and fifty-five patients were prescribed ECT treatment at St Patrick's Hospital in 2001. The hospital had a written policy and procedure on ECT and a dedicated ECT suite comprising three or more rooms, including a separate waiting and recovery room. A named consultant psychiatrist was responsible for the ECT clinic and there was a formal induction process on ECT for all new medical staff. The service had a pre- and post-ECT nursing checklist and the consent form in use was satisfactory. A nurse trained in basic life support was available in the recovery room post-ECT.

The medical preparations policy, which was under review at the time of this inspection, was last reviewed in the year 2000. The prescription card had provision for the prescriber's signature in full and provision for the doctor's name using block lettering, which was very satisfactory. While most prescriptions were in block writing and those that were scripted were not difficult to read, the signatures of some of the prescribers were illegible. Some discontinued prescribed medicines were not dated or signed. A system of drawing a line through discontinued medicines was not satisfactory. There was a need for one signature and one date for each prescription. The standard observed in St Patrick's in this regard was variable. There was provision for recording drug allergies or drug interactions so that information was rapidly available to the staff and this was very satisfactory. There was an increased risk factor of drug error if discontinued prescriptions were greater in number than current prescriptions and this was noted in two wards visited. Written information for patients on prescribed medications was not available, with the exception of literature from pharmaceutical companies on lithium therapy.

The standard of clinical files, which were under review at the time of inspection, was generally satisfactory. 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 each medical file. The patient's name was clearly recorded on each continuation page and a discharge note, which was in triplicate, issued to the GP responsible for follow-up care on the day of discharge. Written instruction on the filing of documentation within the record was required and loose clinical material should not be stored within the medical file.

The overall physical facilities at St Patrick's Hospital were of a high standard. Adequate privacy was provided for patients, with ceiling-to-floor bed screens in multi-bed areas. Most single rooms had en suite facilities. The bathroom and sanitary facilities were clean and well maintained. Patients had access to a shop on the hospital grounds. Emergency trolleys were located at strategic locations throughout the hospital and were checked regularly to ensure medical products were in date and equipment was in working order.

There was a standard classification for incident and accident reporting according to seriousness of outcome, with monitoring and audit of all untoward incidents and accidents. All of this was very satisfactory. There were 924 accidents to patients with no serious injuries during 2001. There were seventy-six assaults on patients by other patients and none were deemed serious. There were thirty-five assaults on staff by patients, fourteen resulting in mild injury, scratches or bruising, and two were deemed serious. A hospital brochure setting out full details of the hospital services was available for the information of patients and relatives. Notices on patients' rights under the Mental Treatment Act, 1945 were prominently displayed. The St Patrick's Patients' Charter was prominently displayed at all locations. Information on the number of complaints made by patients to the local complaints manager was not available. There were thirteen requests under the Freedom of Information Act. While the provisions of this Act did not apply to St Patrick's Hospital, all requests were responded to under the spirit of the Act and dealt with accordingly. There were no research projects undertaken in St Patrick's governed by the Clinical Trials Act 1987-1990. Seclusion was not used in St Patrick's since the last visit of inspection. Six patients were placed on special, one-nurse-to-one-patient, supervision for duty spans of ten hours or more during 2001. There were 297 duty spans of special nursing supervision. Statistical information on the number of voluntary patients re-graded to involuntary status during their hospital stay, or the number of involuntary patients re-graded to voluntary status during their hospital stay was not available. One patient was transferred from St Patrick's Hospital to the Central Mental Hospital under Section 208 of the Mental Treatment Act, 1945 last year. The number of patients taking their own discharge from the hospital against medical advice last year was unknown. The new forms introduced would ensure appropriate follow up for patients taking their discharge against medical advice and appropriate tracking and trending of all discharges.

The management team of this service met on a monthly basis and minutes were kept. The hospital executive met informally on a daily basis to review admissions, discharges and other matters pertinent to the administration of the hospital. There was a fire committee, which met twice yearly, and a safety committee which met quarterly, with appropriate minutes kept of all meetings. There was a formal induction process for all staff and adequate training for staff on cardio-pulmonary resuscitation, management of aggression and violence, safe lifting and manual handling of loads. A written policy was required for

patients absent from the hospital without official leave. The policy and procedure should indicate when a patient went absent without official leave, the responsibility of the hospital to return the patient, who was to take charge of the absent without official leave procedure, how a local search was organised, when and who to contact Gardaí and when and who to contact patients' relatives.

Nursing documentation was audited to assess standard of record and an updated psychiatric nursing care plan was introduced four months prior to this inspection. The file in use in the clinical areas was an integrated file, integrated with the medical notes. An examination of the nursing records showed that the patient's name was recorded on all continuation pages. Records were written clearly and identified problems that had arisen and action taken by nursing staff to rectify them. The name of the patient's primary nurse was entered in each nursing record. The nursing record should reflect the involvement of patients in planning and making choices and decisions about their own care and treatment. They should include entries about patients' wishes, preferences and comments about treatment approaches. Similarly, evaluation of nursing care plans should include patients' views about progress. A written policy about the use of abbreviations was required. While all entries in the nursing notes were accurately dated, the time of entry should be recorded and the nurse making the entry should record their signature in full to enable easier identification of the nurse in future.

A number of patients were asked for their views on the level of services provided. All were reasonably satisfied with the admission process and with the courtesy and helpfulness of staff. All reported being shown around the ward on admission or within a reasonable time thereafter. All patients reported that it was possible to get refreshments within the ward when needed. Patients expressed general satisfaction with the level of recreational, diversional and therapeutic activities during the day, evening and at weekends. All were satisfied with the smoking areas and all reported feeling safe in the ward environment. One patient reported not receiving an information booklet about the hospital. Others were satisfied with the information provided. All were satisfied with aspects of privacy and dignity in relation to their care, reported general satisfaction with the heating, overall cleanliness, sanitary facilities, décor, storage space for clothing and personal belongings and facilities to wash personal clothing. Patients were satisfied with the facilities to meet religious and spiritual needs and all reported easy access to fresh air, accompanied or unaccompanied by staff members. Patients were satisfied with the services provided by their consultant psychiatrists and non-consultant hospital doctors. All patients interviewed were taking prescribed medication and all reported that their consultants discussed the effects and likely side effects of prescribed medication with them. Patients were aware that they had a nursing care plan, but none were aware if a nurse was assigned with primary responsibility for their care. All reported having adequate contact with nursing staff. Patients were satisfied nurses listened to their anxieties and queries about treatment and tried to answer them. When asked to what extent patients had been involved about decisions affecting their care, such as planning their care with the individual doctor or nurse, all patients reported 'not really'. None of the patients interviewed had seen a psychologist during their period of hospitalisation.

The continued registration of this hospital was recommended.

ST PATRICK'S HOSPITAL — SECOND 2002 INSPECTION

INSPECTED ON 5 NOVEMBER, 2002

GENERAL COMMENTS

There were 258 patients in St Patrick's on the day of inspection. St Patrick's provided, apart from an out-patient component, a day hospital service for elderly public psychiatric patients in association with the St James, Area 3, elderly service. However, St Patrick's had ambitions to create day services based on day hospital and other analogous activity for the private hospital. This was a matter for negotiation with regulatory and insurance bodies and, so far, had not met with a great deal of success. However, some day patients attended the eating disorders programme, some of them on a five-day week basis. There had been a general policy change in St Patrick's directed at increasing admissions and decreasing lengths of stay and both of these initiatives appeared to be bearing fruit as the average length of stay had decreased and the number of admissions well exceeded 2,000 per year. Current policy was to make every ward in St Patrick's an admission ward and this had been largely attained. The benefits were that wards would be allocated to individual consultants on an admission basis and would provide for more rationality in relation to their activities and, in particular, ease matters for nursing staff who would form teams with the admitting consultants to their respective wards. This was correctly regarded as an improvement on the former arrangement. Specialisation continued to be encouraged in St Patrick's and, in addition to a relatively long-standing specialised approach to later life psychiatry, specialties included initiatives in eating disorders, perinatal and recalcitrant affective disorders fields.

The number of long-stay patients had declined and, in particular, the number of "catchment area" patients paid for by the Eastern Regional Health Authority who now numbered approximately twelve. These twelve patients were being moved on a phased basis, one by one, to alternative accommodation in other private facilities in the city; the majority of such patients who formerly occupied Emmet Ward, were now elderly. One of the difficulties facing St Patrick's, as perceived by the Inspectorate, was the issue of active rehabilitation rather than recurrent re-admission, for patients with enduring and disabling psychiatric disorder. The lack of community-based facilities and the all-Ireland brief of St Patrick's did not help in this regard.

The extensive refurbishment and rationalization of St Patrick's had been largely completed, although there was still some work to do such as the conversion of all wards to admission purposes. In particular, the acute/intensive care ward at the Dean Swift unit, was now working satisfactorily and it was gratifying to hear that neither special nursing nor seclusion had been employed in recent months. The appointment of an admissions officer and the triaging arrangements in relation to admissions to wards suitable to patient need, including the direct access from the admission area to Dean Swift unit when this was needed, represented a satisfactory arrangement.

The general standards of furnishing, décor, the documentation of policies and procedures and the proposal to provide a copy of the St Patrick's Patients Charter to each patient on admission, in association with the St Patrick's booklet, were all admirable steps forward.

ST EDMUNDSBURY HOSPITAL, DUBLIN 8 — FIRST 2002 INSPECTION

INSPECTED ON 13 MAY, 2002

IN-PATIENT CARE

In-patient care was provided at St. Edmundsbury Hospital, Dublin, where fifty beds were provided.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	—	6	9	5	2	22	95.65
3 to 12 Months	—	—	—	1	—	—	1	4.35
1 to 5 Years	—	—	—	—	—	—	—	—
Over 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	—	6	10	5	2	23	100
% of Total	—	—	26.1	43.5	21.7	8.7	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
1	—	—	20	—	1
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
1	—	—	—	—	23

Status of In-Patients on the date of first inspection 2002

Status	Male	Female	Total
Voluntary	13	33	46
Temporary	—	—	—
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	13	33	46

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate	No.	% of all	Voluntary	non-voluntary		
412	—	148	35.9	100	—	408	—

GENERAL COMMENTS

The new building now contained forty-four single bedrooms and three double bedrooms, all en suite. In addition, there were two extra bathrooms, one with a Parker bath for older patients. There was also a clinical room, a nurses' office, a tearoom and a hairdressers' room. The old building was used mainly for therapies, and also contained the patient and staff dining areas. The consultant psychiatrists had their offices here and so also had the psychologist, the family therapist, the occupational therapist and the cognitive behavioural therapist. There was also a small, four-bedroomed nurses' residence here. There was an occupational therapy department, a sitting room, a music room, a coffee dock and a beauty therapy unit.

On the day of inspection, there were forty-six patients in residence in the integrated new building, thirty-three female and thirteen male. None of these patients had alcohol-related disorders; the majority had diagnoses of affective disorder. Medical cover was provided by about six consultant psychiatrists from St Patrick's Hospital, with a good degree of sub-specialisation, while GP services were provided by a local practice. The total nurse complement was two clinical nurse managers, Grade II, four full-time staff nurses, four job-sharing RPNs and two part-time SRNs. There was one vacancy, that of Senior Nurse Manager. Night cover was provided by one psychiatric nurse Staff Nurse grade, plus one nurses' aide.

There had been no changes of any substance since the last visit of inspection. The standards of décor, hygiene and patient care were high. The substantial farmland that was attached to this complex was sold off, as noted in previous reports, and the deterioration of these once beautiful pastures was quite noticeable.

As regards fire precautions, there was a high-quality fire-alarm system in situ. The fire officer attached to St Patrick's Hospital inspected the equipment in addition to giving lectures and demonstrations to staff.

From the clinical viewpoint, seclusion and restraint were not features of this service, but neither were individual patient care plans or formal complaint procedures.

The overall ambience of St Edmundsbury was quite therapeutic and both patient and staff morale was quite high. A hospital chaplain visited on a weekly basis and a security firm provided security cover daily from 7.00 p.m. to 7.00 a.m.

The continued registration under the mental treatment legislation of St Edmundsbury Hoapital was recommended.

ST EDMUNDSBURY HOSPITAL, DUBLIN 8 — SECOND 2002 INSPECTION

INSPECTED ON 9 DECEMBER, 2002

GENERAL COMMENTS

St Edmundsbury Hospital was a single-storey building around a central courtyard garden and accommodation consisted of single en-suite rooms and three double rooms. Forty-three patients were present at the time of inspection and all were voluntary. Staffing consisted of five nurses assisted by care staff. There was a full-time psychologist and occupational therapist. There were two NCHDs, who were assisted by a local general practice. Some of the St Patrick’s consultants were on call at the evenings and weekends, if needed. One consultant did most of the work but there was a possibility that another consultant would join as a major player with an eating disorders programme. At the same time, other consultants from St Patrick’s did have a small number of patients from time to time. Generally speaking, patients treated were those with minor illnesses. There was a policy of admitting and treating only voluntary patients. Should patients become more seriously ill, they would be transferred to the special care unit in St Patrick’s. The length of stay on each individual admission had come down. Needless to say, all decorative, furnishing and structural matters were in order and of good quality.

ST JOHN OF GOD HOSPITAL — FIRST 2002 INSPECTION

INSPECTED ON 26 MARCH, 2002

IN-PATIENT CARE

In-patient care, both private and public, was provided at St John of God Hospital, which had 195 beds.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	3	33	21	10	6	73	87.95
3 to 12 Months	—	—	1	1	2	2	6	7.23
1 to 5 Years	—	—	1	1	—	—	2	2.41
Over 5 Years	—	—	—	2	—	—	2	2.41
All Lengths of Stay	—	3	35	25	12	8	83	100
% of Total	—	3.61	42.16	30.12	14.45	9.63	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
4	24	—	29	10	7
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
2	7	—	—	—	83

Status of In-Patients on the date of first inspection 2002

Status	Male	Female	Total
Voluntary	61	72	133
Temporary	10	10	20
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	71	82	153

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate	No.	% of all	Voluntary	non-voluntary		
1,101	—	623	56.6	93.4	6.6	1,105	5

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
11	20	96.5	67.5	14.5

GENERAL COMMENTS

Since its foundation in 1882, St John of God Hospital in Stillorgan had provided assessment, treatment, rehabilitation and ongoing care of a high standard for people with mental illness. The hospital had six integrated nursing units with a total bed complement of 195, and accommodated 112 private patients on the day of inspection, forty-seven male and sixty-five female. Eight of the private patients were hospitalised on temporary certificates. In addition, St John of God Hospital provided public in-patient beds for the Dublin South East (Area 1) catchment area, which had its administrative and clinical headquarters at the Cluain Mhuire Family Centre, Blackrock. There were forty-one public patients hospitalised in St John of God’s on the day of inspection, twenty-one male and twenty female. Eleven, eight male and three female, were hospitalised on temporary certificates. Of the 195 beds, 153 were occupied on the day of inspection. The physical environment in which care and treatment was provided at St John of God’s Hospital was of a very high standard. The continued development, upgrading and maintenance of the hospital and its grounds, the commitment of management and staff to the maintenance and upkeep of an excellent therapeutic environment was commendable.

Of particular pride to the hospital was the completion at the end of 2001 of the hospital's new admission unit, providing a total of fifty-two in-patient beds within single and twin-bed en suite units on the top floor of the new wing of the hospital. This new unit, of which twenty-eight beds had opened at the time of this visit of inspection, was designed to the highest quality standards, with excellent décor, observation and treatment facilities. The opening of twenty-five beds of this fifty-two bed unit facilitated the closure of St Joseph's unit. St Joseph's unit was used as a pre-discharge unit which had now been replaced with medium-dependency beds and this had had a significant impact on the hospital's ability to deal with urgent requests for admission. The waiting list of thirty to forty patients per day had now reduced to ten, and most of those patients could be accommodated within a waiting period of a maximum of twenty-four hours. It was anticipated that the waiting period would be reduced further with the opening of the additional twenty-five beds. Hospital consultants admitted patients to St Joseph's Ward and Cluain Mhuire Family Centre consultants admitted patients to St Paul's. This had led to considerable reduction in internal transfers within the hospital, had ensured reasonable continuity of nursing care and, in turn, had reduced the large inputs of clinical teams into St Paul's unit. This rationalisation of service provision within the hospital was welcomed.

The sixteen-bed adolescent unit, which closed a number of years ago due to nurse staffing difficulties, remained closed. It was a pity that such a fine unit remained unoccupied and every effort should be made to have this unit reopened now that the nurse staffing situation appeared to be improving. Nursing recruitment continued to be the prime focus for St John of God Hospital, with interviews at various locations throughout the country and abroad. In addition to the hospital's participation in the Order's recruitment fairs, video conferencing in the recruitment of nursing staff from Australia and New Zealand commenced. This very pro-active stance on the part of the hospital to deal with an emerging crisis for all mental health services in the Dublin region had proved reasonably successful, with an increased number of nursing personnel at ward level. In addition, the interim introduction of the Nursing Assistant Grade, with appropriate educational and training support both from within the hospital and through external agencies had also proved successful. The improved number of nursing personnel facilitated the welcome re-introduction of continuing nursing education within the hospital. A considerable number of nursing staff participated in in-service training courses on patient lifting techniques, basic CPR, break-away techniques and venepuncture. Significant progress in in-house training was made during 2001 as compared to the previous year and this was welcomed. As part of its nursing recruitment and retention campaign, this service designed and provided a return to psychiatric nursing practice course which received Category 1 approval from An Bord Altranais. However, the uptake was poor despite the service contacting nursing personnel who had left employment within the service. It was the intention to remarket this programme in 2002.

St John of God Hospital provided a specialist eating disorders recovery programme and since the last inspection the numbers had increased, with more patients attending on a day-patient basis where possible. Seven patients in total attended as day patients, two of whom completed the full programme as day patients. The remainder commenced as in-patients and then completed the programme as day patients. Fifty after-care groups were

held in addition to twenty-four family support groups. Twenty-seven patients participated in the eating disorders recovery programme in 2001, as compared to sixteen the previous year.

A comprehensive and well-laid-out annual 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 years and targets for the years ahead. The report also contained statistical data relating to services provided. Other services should follow this example of a comprehensive review of service provision by various department heads.

The importance and value of policies, procedures and guideline documentation had been recognised. All policies procedures and guidelines within the service were under review at the time of this visit of inspection. Each revised and updated policy procedure or guideline should be headed with the hospital title, individually numbered, the date of ratification recorded, and by whom, with an appropriate review and audit date. A computerised index of all hospital policies, procedures and guidelines should be kept and superseded policies should be stored at a central location for reference purposes.

There were seventy-three involuntary admissions to St John of God Hospital in 2001. Thirty-two patients admitted as voluntary patients were regraded to involuntary status and there were eleven extensions of involuntary admission orders. Involuntary admission forms were checked and were all found to be completed satisfactorily.

There were thirty-nine episodes of seclusion involving five patients in the year 2001. A seclusion register was maintained and fifteen-minute observations by nursing staff appropriately recorded. The seclusion room provided adequate privacy for patients. No room furnishings were provided. The policy and procedure relating to seclusion was dated 1996 and required review and updating. This was to be done as part of the overall review of policies and procedures. In the course of this inspection a patient was noted in the area described as high observation. This patient was, in fact, secluded under the terms of the Mental Treatment Act, 1945 and Amending Legislation Section 6(1)(a), which states: 'Seclusion of a patient in a mental institution means the placing of a patient (except during the hours fixed generally for the patients in the institution 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 the egress of the patient.' The provisions as set out in 4(a)(d) of the Mental Treatment Act, 1945 in addition to the local policy and procedure, should apply to all patients placed in the locked, high-observation room. There should be a regular audit of the use of seclusion, both in the high-observation room and in the adjacent special safe room. A separate policy and procedure should be produced for time out, which should never include the use of a locked room and should be clearly distinguished from seclusion, which was for use in an emergency only and should never form part of a behavioural programme. Time out, if used, should ordinarily not take place in a room which is used for seclusion on other occasions and be used only as part of a planned approach to managing difficult or disturbed patients. Detailed and contemporaneous records should be kept in the patient's case notes and nursing notes of any use of seclusion, the reasons for its use and subsequent

activity, cross-referenced to a seclusion register which should include a step-by-step account of the seclusion procedure in every instance. Hospital management should audit the use of seclusion, including seclusion in the high-observation area, regularly to ensure that it is properly used.

One-nurse-to-one-patient special nursing supervision had been used at St John of God Hospital on three occasions in the past year. There was a complaints procedure available within the hospital which was displayed at some locations for the information of patients and relatives. While there was a complaints procedure and a nominated complaints manager, information relating to the number of complaints made and outcome was not available at the time of inspection. Management should closely monitor the handling and outcome of all complaints both to ensure minimum delay and to note any quality implications arising from the complaint.

The management team of this service met on a two-weekly basis and minutes were kept. There was a reformed safety committee incorporating the fire committee which met regularly and appropriate minutes were kept. There was a formal induction process for all new staff and records were kept of the names of the staff participating and the content of the training programme.

Thirty-four patients were prescribed ECT during the year. There was a dedicated ECT suite and the Royal College of Psychiatrists handbook was available. A named consultant psychiatrist was responsible for the ECT clinic and there was an induction process for all new doctors. A nurse trained in basic life support was available in the recovery room following the ECT procedure. The consent form in use was satisfactory. A pre- and post-ECT nursing checklist should be introduced and this should be incorporated into the revised and updated nursing procedure relating to ECT.

There were no research projects undertaken in this hospital governed by the Clinical Trials Act 1987 — 1990. Hospital procedures operated under the spirit of the Freedom of Information Act and all requests were processed in the same manner. Statistical data relating to applications for information were not available at the time of this inspection.

There were 220 recorded accidents to patients and twenty-three recorded accidents to staff at the hospital in 2001, but none were categorised according to seriousness of outcome. The hospital was undertaking an audit of accidents and injuries with a view to establishing tracking and trending of accidents and assaults so that insights might be gained in relation to both. One patient was transferred from St John of God Hospital to the Central Mental Hospital under Section 208 of the Mental Treatment Act, 1945 since the last visit of inspection. The patient remained at the Central Mental Hospital at the time of this inspection.

Case notes in relation to involuntary patients and Section 208 patients transferred to the Central Mental Hospital were examined. Medical assessments prior to decisions to detain patients were appropriately recorded in the medical notes. The temporary admission forms were also inspected and found to be completed satisfactorily.

A number of clinical files picked at random 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 and all of this was appropriately recorded. The signature of the doctor making entries in the notes should always be legible and designation should be recorded. Ideally, the professional staff member making the entry should write his or her name in capitals, then sign the entry and then record his or her designation. This would enable identification of the practitioner in the future. The dates of all entries were recorded in the notes. Time of entry was not recorded. Recording of time was useful in determining any delays in assessment or treatment. The patient's name was not always recorded on each continuation page. Written instructions on filing of documentation within the medical record was required. Some files contained loose clinical material in a folder at the back of the file. Risks associated with the storage of loose clinical material within a file include delay in accessing pertinent information and loss of misfiled information as the contents were not secure.

A comprehensive hospital brochure outlining full details on hospital services was available for patients' information and reference. Emergency resuscitation trolleys were placed at appropriate locations throughout the hospital. These were checked regularly to ensure medication was within date and equipment was in working order.

There was a written policy for the ordering, prescribing, storing and administration of medicines. A number of individual patient prescriptions were checked at random. Some prescriptions were block written, others were scripted but were not difficult to read. While all prescriptions were dated individually, not all were signed in full. Ideally, all prescriptions should be signed in full by the prescriber. There was provision for recording the date and signature for the discontinuation of each prescription, but this was not always completed. The drug administration recording card had provision for the nurse's signature in full. Most, but not all, cards examined were completed satisfactorily. A system of checking and auditing should be introduced to ensure that all nursing staff administering prescribed medications recorded their signature in full. There was provision on the prescription card for recording drug allergies so that information was rapidly available to staff. Written information on the likely effects and likely side effects of medication should be available for patients and a note on the verbal explanation given to patients before treatment commenced should be recorded in the case notes.

Nursing care plans using the "Orem" model of nursing were appropriately recorded and reviewed on a weekly basis, or more often if clinically appropriate. The patient's primary nurse was entered in the nursing record and records examined confirmed that patients appeared to settle well into the ward at the end of their first day of hospitalisation. Records were written clearly so that text could not be erased and all notes examined were easily readable on photocopies. The patient's name should be recorded on each continuation page. Ideally, records should reflect the involvement of patients in planning and making choices and decisions about their own care and treatment, with appropriate entries about patients' wishes, preferences and suggestions. Similarly, nursing evaluations should include patients' views about progress. The records should reflect the patients' opportunities to talk about their illness or other matters pertinent to their care in hospital.

A number of patients were interviewed to ascertain their views on the care provided. All were satisfied that they were appropriately introduced to the professional team responsible for their care. Patients were generally satisfied with the courtesy and helpfulness of staff, access to their consultant psychiatrist while hospitalised, and access to services when deemed appropriate. All reported being informed about the nature of their medical condition, including prescribed medicines and all reported understanding the information given. All patients interviewed were voluntary patients and all reported an understanding of their rights under the Mental Treatment Act, 1945. Patients found the ward environments cheerful, homely, clean and supportive. All reported that the sleeping arrangements were adequate and it was possible to get a restful night's sleep without interruption. Patients were generally satisfied with the occupational therapy and the recreational and diversional therapies available and all reported finding them helpful. All patients were aware of the name of their primary nurse and all felt they had adequate contact with nursing staff while hospitalised. Patients reported easy access to the telephone, access to hot and cold drinks and access to fresh air, accompanied or unaccompanied, if appropriate. One patient expressed a dislike for participating in multi-disciplinary case conferences, expressing a wish to see the consultant or medical staff member individually. The patient concerned found the multi-disciplinary meetings stressful but had not relayed this to any staff member. Patients should be informed of their right to see a clinician on an individual basis and, if asked to participate in multi-disciplinary meetings or case conferences, appropriate explanations and reassurance should be given to the patient beforehand in order to prepare them for what may be a stressful situation for some.

Overall, the standards of furnishings, hygiene, privacy, décor and professional care at St John of God Hospital was of a high order and I have no hesitation in recommending its continued registration.

ST JOHN OF GOD HOSPITAL — SECOND 2002 INSPECTION

INSPECTED ON 22 NOVEMBER, 2002

GENERAL DESCRIPTION OF THE SERVICE

The capacity here was 181 beds and there were 155 patients in residence at the time of inspection, though thirty-nine were from the catchment area services provided by Cluain Mhuire. A certain proportion of Cluain Mhuire patients were private patients, predominantly from the catchment area. Generally speaking, the percentage of Cluain Mhuire patients that were private was of the order of 20-25%.

GENERAL COMMENTS

St John of God Hospital was equipped and furnished to the highest standard and patients were catered for in either twin or single bedrooms with a small number of bedrooms for four patients, most of them en-suite. St Paul's Ward served as the admission unit for the Cluain Mhuire catchment area. A proportion of the patients were of private status. St Peter's Ward was the closed ward for more seriously ill patients and also provided for

seclusion and contained a mixture of public and private patients, with the former predominating. St Camillus Ward was a composite consisting of St Mary’s, St Augustine’s and St John of God’s, all of which occupied separate corridors. The St John of God corridor was devoted predominantly to persons with alcohol disorders and the other two as specifically designated. The Inspectorate had in the past expressed some concern about the observation facilities in relation to these wards, particularly at night. The timed observation arrangements currently in place had allayed any anxieties on this matter. The Carrickdubh and Carrickfergus units catered for elderly persons, though not everyone therein was elderly. Carrickdubh was oriented towards the care of persons with functional illness and Carrickfergus catered for persons with organic disorders and some of the beds were set aside for respite function with quite a number coming and going during the year. The sixteen-bed adolescent unit, St Anne’s, remained closed due to the difficulty in recruiting nursing staff. This problem seemed to be rectifying itself and there were aspirations that the unit would re-open.

There was little to add to the general comments of the visit of inspection in March, other than to emphasis again the generally high standards, functioning and décor which characterised this hospital.

BLOOMFIELD HOSPITAL, DONNYBROOK — FIRST 2002 INSPECTION
INSPECTED ON 22 MAY, 2002

IN-PATIENT CARE

In-patient care was provided at Bloomfield Hospital, which had a total of forty beds in one male and one female ward.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	—	—	—	—	—	—	
3 to 12 Months	—	—	—	—	—	—	—	
1 to 5 Years	—	—	—	6	30	—	36	
Over 5 Years	—	—	—	—	—	—	—	
All Lengths of Stay	—	—	—	6	30	—	36	100
% of Total	—	—	—	16.67	83.33	—	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
2	13	10	2	—	—
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
—	8	—	1	—	36

Status of In-Patients on the date of inspection 2002

Status	Male	Female	Total
Voluntary	20	16	36
Temporary	—	—	—
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	20	16	36

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate	No.	% of all	Voluntary	non-voluntary		
10	—	n/a	n/a	100	—	—	12

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
1	3	23	1.5	—

GENERAL COMMENTS

On the last number of inspections of Bloomfield, it was speculated that the three component parts of this complex, Bloomfield, New Lodge and Westfield, were to be sold off and one new, purpose-built unit on a green-field site was to replace them. This was, apparently, very much on the cards and negotiations for the sale were at an advantaged stage. It was hoped that a new complex would replace them at Rathfarnham.

Of the three component parts, only Bloomfield came within the remit of the Inspectorate because it was a registered psychiatric facility. This was formerly the residence of the patriot, Robert Emmet. It was purchased by the Society of Friends and opened as a hospital in 1812, specifically to cater for the mentally ill. It gradually evolved so that now it catered for the psychiatric problems of older persons.

The unit, in the main, was a three-storey building. The top floor had been vacated and patient numbers were reduced to thirty-six — twenty male and sixteen female. The ground floor, St Luke’s Ward, was the dormitory area for most of the male patients. St Martha’s Ward, in addition to sleeping the female and some male patients, was the day area for all patients. All the patients in residence were of voluntary status. The majority of patients

were sourced from the ERHA, particularly from the psychiatry of later life services. As negotiations for sale were in progress, there had been no developments of any significance since the last inspection. Nevertheless, the décor, furnishings, etc., were of a high order. In the recent past, St Martha's and St Luke's Wards were painted, as were the conservatories.

Prescribed medicines were delivered from a pharmacy in a blister-pack system. The blister-pack for each patient contained the patient's name, photograph and a weekly supply of medicine, which was dispensed by a nurse from an ultra-modern drug trolley. The medications were formally prescribed by the medical personnel. There was a formal patient review procedure in operation. Every patient was reviewed weekly for the first month, then monthly for three months, and thereafter a full assessment was carried out at six-monthly intervals, or more frequently if required. All these reviews were properly recorded in case notes. In addition, there were three-monthly blood assessments carried out. These were full blood examinations and medicinal blood levels. All these results were properly recorded.

The nursing staff complement was composed of a matron, an assistant matron and a ward sister. Two of the above were on duty each day, in addition to two part-time staff nurses plus four 'assistant nurses'. The latter designation was given to four staff recently recruited. At night time there was one staff nurse and two assistant nurses on duty. In addition, there was one male attendant who washed and shaved the male patients, in addition to general portering duties, and one male nursing aide whose work was more patient centred.

In the nursing office were the nurses' procedure book and the nursing policy book, which were readily accessible to all staff. Staff had been trained in manual handling and lifting techniques. There was a special complaints procedure and all patients had individual care plans, with nursing inputs both daily and nightly.

The standard of hygiene was quite high and this was noted both in patients' personal clothing and in the bed-linen, towelling, etc. All in all, high standards were maintained here and the staff merited commendation for same.

The continued registration of Bloomfield Hospital under the mental treatment legislation was recommended.

BLOOMFIELD HOSPITAL — SECOND 2002 INSPECTION

INSPECTED ON 26 NOVEMBER, 2002

GENERAL COMMENTS

This building was essentially a mid to late eighteenth century house standing on its own grounds, with thirty eight patients, thirteen were female. All patients were aged over sixty-five years, three patients were wards of court and the remainder were voluntary. The majority of the patients were from two services, one was from Areas 6 and 7 and the other from Area 1. Staffing consisted of two nurses and four care attendants by day and one staff nurse and two care attendants by night. A medicine trolley had been acquired since the last visit of inspection, and medications were now administered from blister packs packed by the pharmacist; this was greatly appreciated by staff. Sleeping accommodation consisted of either single or double rooms or occasionally threesomes off two corridors at right angles to one another, and in the corner of them a large day space that opened into a conservatory, and off one of the corridors was the dining room. Food was prepared externally by a catering firm and delivered in hot trolleys but prepared in the unit’s own kitchen.

HIGHFIELD AND HAMPSTEAD HOSPITAL — FIRST 2002 INSPECTION

INSPECTED ON 4 JUNE, 2002

GENERAL DESCRIPTION OF THE SERVICE

There were four components to this hospital complex; Hampstead and Elmhurst Units on the western side of the Dublin — Belfast road and Highfield and the Alzheimer Units on the eastern side. Hampstead and Highfield remained within the remit of the Inspectorate as both were designated centres under the Mental Treatment Act, 1945.

IN-PATIENT CARE

In-patient care was provided at Highfield and Hampstead Hospitals, which had a total of eighty-two beds.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	—	—	2	1	—	3	3.75
3 to 12 Months	—	—	—	2	15	—	17	21.25
1 to 5 Years	—	—	—	1	31	9	41	51.25
Over 5 Years	—	—	—	1	16	2	19	23.75
All Lengths of Stay	—	—	—	6	63	11	80	100
% of Total	—	—	—	7.5	78.75	13.75	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
49	12	3	6	1	1
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
3	—	—	1	4	80

Status of In-Patients on the date of first inspection 2002

Status	Male	Female	Total
Voluntary	35	36	71
Temporary	—	—	—
P.U.M.	—	—	—
Ward of Court	—	6	6
Total	35	42	77

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate	No.	% of all	Voluntary	non-voluntary		
70	—	n/a	n/a	100	—	39	12

HIGHFIELD HOSPITAL

This unit had forty-two female patients at the time of inspection. All were of voluntary status, except six who were wards of court. The patients’ ages ranged from fifty-four to ninety-three years. Medical cover was provided by the medical director and locum consultants on weekends. Paramedical staff were employed as the need arose. The staff complement of nursing and nursing aides was ten per day; two staff nurses and eight care aides by day and one staff nurse and four care aides by night. While there was no input from psychologist, social worker or occupational therapist, there was an activities co-ordinator who worked Monday to Friday, 9.00 a.m. to 5.00 p.m. Activities involved were arts and crafts, flower arranging, reflexology, music and Sonas programmes. The latter was where music and movement were utilised to provide activation. Reminiscence therapy was also carried out. Structural changes since the last inspection consisted mainly of a total electrical re-wiring of the entire unit. This was quite a difficult task as all wires had to be carried in conduit piping, which proved quite difficult for subsequent decorative camouflaging. Other works carried out, or in the process of being done, were painting of the top floor and some major works in the kitchen and catering departments.

From the clinical/management perspective, various documents were examined. The nurse procedure and policy book had been reviewed in 2002. There was a comprehensive health and safety statement manual. Very detailed editions of this were available in the nursing stations of both Hampstead and Highfield hospitals, while a slimmed-down version was

given to each member of the care staff. There was also an Accreditation Programme. This was to ensure the equivalent of a quality mark in standards of care, procedure and practices. This was a new development and was soon due for an accreditation audit. For this purpose, an initial audit was to be carried out by a team from England consisting of a senior nurse, an administrator and a consultant psychiatrist.

As regards nursing models of care, the hospital was implementing a new model that incorporated mainly the “Orem” principles. There were individual care plans for each patient. The nursing notes examined were quite satisfactory; the medical notes were confined to the medical director’s office. An information booklet was available in all reception areas and on request. There was a formal accident recording book, and the three issues of complaints, accidents and incidents have now been combined into this book.

The fire procedures were satisfactory. This had been enhanced by the Hospital Insurance Agency insisting that there was a mandatory input each six months by a registered fire officer. This included lectures, demonstrations of procedures and examination of fire appliances. All the patient areas had high standards of hygiene and décor and the patients appeared quite happy. Patients’ clothing, bed linen, towels, etc., were of very good quality.

HAMPSTEAD HOSPITAL

There were thirty-five patients in residence here; thirty of voluntary status and three Wards of Court, with ages ranging from fifty-seven to eighty-two years. Hamstead Hospital came under the control of the Director of Nursing Highfield Hospital following the retirement of the Matron of Hampstead Hospital. From an administrative viewpoint this was a welcome development.

There had been no structural changes of significance since the last inspection, but signs of the extensive electrical re-wiring were much in evidence. The overall standards of care and décor were quite good. Comments re the clinical aspects, such as case notes, nursing procedures, etc., made in respect of Highfield Hospital also applied here.

The Inspectorate recommends the continued registration of both Hampstead and Highfield Hospitals under the mental treatment legislation.

INSPECTED ON 26 NOVEMBER, 2002

HIGHFIELD HOSPITAL

Highfield Hospital was a detached three-storey house standing on its own grounds and was part of the Highfield, Hampstead, Elmhurst and Alzheimer Unit complex. It was primarily dedicated to the care of the elderly, as was Hampstead. There were thirty-seven patients present at the time of inspection, all female and over sixty-five and all were voluntary patients. One patient, the thirty-eighth, had been transferred to St Patrick's. In addition to the thirty-seven residents, there was one day patient who attended every day from Monday to Friday. There were thirteen patients on the ground floor, a mixture of dependent and non-dependent patients, with eight being dependent to the point that they needed hand-feeding. Staffing consisted of staff nurses and assistants, an occupational therapist attended every Friday and a physiotherapist approximately once a month. Downstairs consisted of the day room, used for occupational activities, a dining room and sleeping accommodation. There was a very attractive enclosed garden area at the back. The first floor contained further sleeping accommodation in groups of single rooms. Highfield was being re-wired.

HAMPSTEAD HOSPITAL

Hampstead Hospital was another large building in the extensive Highfield Hospital complex. The two-storey building dated from the eighteenth century and was dedicated to the care of the elderly. There were thirty-eight patients present at the time of inspection, all of whom were male, all but three were over sixty-five and all were voluntary. Staffing consisted of two nurses and six care assistants. Accommodation in Hampstead was essentially on two floors. The ground floor had recently been re-decorated and off the corridor there were eighteen bed rooms, all single with the remainder being double. There were only six patients able to self-feed, the rest needed hand-feeding. Three patients, whose rooms were upstairs, came downstairs during the day. Downstairs, as upstairs, there was a satisfactory level of equipment for bathing, hoisting, etc. The first floor, was arranged around a linear corridor, with sleeping accommodation in six single rooms, except for one which was six-bedded. Clothing was personalised and new arrangements for each person to have their own wardrobe in the six-bedded room were under way. The laundry was situated in Hampstead and catered for Highfield, Hampstead and Elmhurst. The occupational therapist who visited Highfield, also came to Hampstead once or twice a week. The day room was large and commodious, however there was no separate smoking area. There were two dining rooms, one for those who needed more assistance. Decoration of the accommodation on this floor and the floor above was taking place; mostly in single rooms.

Medical cover was provided by the medical director and locum consultants on weekends.

INSPECTED ON 3 MAY, 2002

In-patient care was provided at the Kylemore Clinic, which had thirty-eight beds.

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	—	—	—	1	2	3	8.11
3 to 12 Months	—	—	—	1	—	5	6	16.22
1 to 5 Years	—	—	1	5	1	9	16	43.24
Over 5 Years	—	—	—	3	1	8	12	32.43
All Lengths of Stay	—	—	1	9	3	24	37	100
% of Total	—	—	2.7	24.32	8.11	64.87	100	

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
28	3	—	2	3	—
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
—	—	—	—	1	37

Status	Male	Female	Total
Voluntary	11	26	37
Temporary	—	—	—
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	11	26	37

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate	No.	% of all	Voluntary	non-voluntary		
11	—	—	—	81.8	18.2	2	9

Medical	Administrative	Nursing	Non-Nursing	Other Professional
2	2	28	8	1

GENERAL COMMENTS

This clinic had been described in detail on many occasions in recent years and there had been no change of any substantial nature in the past year. As noted previously, some acres of these reasonably spacious grounds were sold to a builder for a private development. It was envisaged that this development would not compromise the splendid views from the patients' sitting and dining rooms as that area was surrounded by mature trees. Regrettably, the developer became ill and no work on the site had commenced at all.

The clinic authorities informed the Inspectorate that they intended to build a purpose-built fifty-six-bed replacement hospital complex. This was to contain two 'dementia units' and also a unit for the 'frail elderly'. Apparently, financial constraints had inhibited any movement on this project and so the present system with all its shortcomings was set to remain in situ. Despite the fact that they had some splendid rooms, the multiplicity of awkward staircases and stairwells made it quite difficult for elderly patients.

On the day of inspection there were thirty-seven patients in residence, twenty-six female and eleven male. Their ages ranged from thirty-five years upwards, but the vast majority were elderly. The thirty-five-year-old patient suffered from Asperger's syndrome. There were three patients in the fifty to sixty year age group and the remaining thirty-three patients were quite elderly and practically all suffered from dementia, either of vascular or Alzheimer origin. Of the total complement, three patients suffered from schizophrenia and two from Korsakov's psychoses. The older woman who inhabited the flat off the courtyard had had a recent fall and was currently in the main part of the house and, although in her nineties, she was expected to resume occupation of her flat in the immediate future.

The clinic facilities, from a décor viewpoint, were very well maintained but no major development would occur until a definite decision was made re the proposed fifty-six-bed unit. Recruitment of nursing staff, like all hospitals on the Eastern seaboard, remained quite a problem. The nursing complement was: one matron; one deputy matron, recently recruited; nine staff nurses; sixteen female nursing aides; and a male orderly who worked chiefly with patients. An occupational therapist worked two half days weekly and a reminiscence-cum-music therapist worked three days per week. An OT unit was provided off the enclosed courtyard on the western aspect of the house. The administrative staff consisted of the secretary/manager and his assistant. The kitchen staff comprised a chef, a cook and four female domestic staff. Cleaning was carried out by contract. The garden and lawns were in good shape and the gardener was to be commended for his work, which was greatly appreciated by the patients.

The admission and discharge statistics are provided in the statistics column. The fire alarm systems were satisfactory and relevant lectures were provided three times yearly by an insurance adviser who also carried out safety audits. The medical notes were satisfactory but the nursing input system needed developing. There was not a nursing model in situ, but its provision was seen as a priority for the incoming Director of Nursing.

The standards of hygiene and décor for patients were excellent and patients’ personal clothing, bed linen, bathroom requisites, etc. were very satisfactory.

The continued registration under the mental treatment legislation of Kylemore Clinic was recommended.

**KYLEMORE CLINIC, DÚN LAOGHAIRE/RATHDOWN
— SECOND 2002 INSPECTION**

INSPECTED ON 26 NOVEMBER, 2002

GENERAL COMMENTS

There were thirty-seven patients, male and female, at the time of inspection, most were female voluntary and long-stay. There was a psychiatrist in attendance and a medical practitioner looked after the physical needs of the residents and visited once a week and was in addition available on-call. Fire precautions were exemplary with fire exits clearly indicated. The day area was on the ground floor in a spacious reception room as was the spacious main dining room. Some sleeping accommodation was available on this floor where shared rooms were curtained and railed. There was an element of overcrowding.

A new Director of Nursing had taken over and a review of policies, procedures and documentation, and risk assessment were being proceeded with. In addition, a new prescription card to replace the old cardex was to be introduced. This was a good idea as some of the prescriptions dated back to 1999 and had not been reviewed since then. In addition to the fire proposals alluded to above, fire blankets were supplied to all of the rooms and staff were undergoing instruction on their usage.

Plans for the new Kylemore Clinic were to proceed in the near future. Some land had been sold off to finance this undertaking, which would involve building four units, one of which would be an Alzheimer unit. Two of these units were being proceeded with on the existing grounds and two further units erected when the main building was demolished.

PALMERSTOWN VIEW, STEWART’S HOSPITAL
— FIRST 2002 INSPECTION

INSPECTED ON 30 MAY, 2002

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 that had served this purpose for many years and which was situated on the periphery of the campus and which had since been sold off.

IN-PATIENT CARE

In-patient care was provided at Palmerstown View in one eight-bed unit.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	—	—	—	—	—	—	—
3 to 12 Months	—	—	—	—	—	—	—	—
1 to 5 Years	—	—	1	—	—	—	1	25
Over 5 Years	—	—	3	—	—	—	3	75
All Lengths of Stay	—	—	4	—	—	—	4	100
% of Total	—	—	100	—	—	—	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	—	—	—	—	—
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
—	—	—	4	—	4

Status of In-Patients on the date of inspection 2002

Status	Male	Female	Total
Voluntary	5	—	5
Temporary	—	—	—
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	5	—	5

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

All Admissions		First Admissions		Legal Status(%)		Discharges	Deaths
No.	Rate	No.	% of all	Voluntary	non-voluntary		
1	—	—	—	100	—	1	—

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
2	—	11	1	3

GENERAL COMMENTS

There were five patients in residence, all male, and it was interesting to note that four of these were part of the original complement on the opening day in March 1979. The fifth patient was transferred here from a unit on campus in January 2002.

Just recently, a patient was discharged back to the Western Health Board. The patient was resident for many months and, in addition to his learning disability, suffered from extreme behavioural disorder and posed quite a management problem. One of the bedrooms had to be specially modified for this patient. This room might now be used as a back-up facility to the seclusion room if necessary.

Recently, the question of admitting a female patient to this unit arose and it was decided to postpone admission until suitable toilet facilities were arranged and it was expected that work on this would commence in the near future.

There were no other developments of note during the year, apart from a small garden project within the curtilage of the bungalow, where it was hoped to grow some vegetables. All the components of the unit, such as bedrooms, toilets, dining area and day area, were quite satisfactory, with a high standard of hygiene. On noting the absence of toilet seats, it was explained that this was a matter of policy as too often in the past they had been capable of being easily broken and became dangerous implements. The taps on the wash-basin were also removed on purpose because one resident was a compulsive water drinker. However, there was a valve mechanism that was used when patients wished to use the hand-basins.

The staff complement was: one Clinical Nurse Manager II, one Clinical Nurse Manager I, two care staff and one household staff by day; and one care staff at night. Night staff used a radio system and panic buttons to summon immediate assistance from adjacent units if needed, but there had been a noticeable decrease in their use once the staff became familiarised with their patients.

The following policies and procedures were perused and discussed at some length. The Assault Book, which provided the names of the patient involved and the person assaulted. There were fifty-five assaults by patients on staff and fifty-one assaults by patients on patients. There was one Accident and Incident File for each patient. On the

front page was an identifying photograph of the patient and then all incidents relating to each patient were filed as they occurred and copied to the clinical director.

The Policy Book was a very good compendium that was accessed by all care staff and had been updated in the previous six months. The Handbook of Nursing Procedures was also quite good. It had been updated in 2000 and was due for review in the coming months. The Safety Statement, Stewart’s Hospital was quite a voluminous document containing some 250 pages. Each member of the staff had been given their own personal copy. Because of this, staff members were much more au fait with all aspects of safety measures.

Following recommendation from the Inspectorate, all seclusion orders had full medical signatures rather than initials. There were 187 episodes of seclusion in the year 2001, all properly authorised and recorded in the register. In conjunction with the seclusion register was the Nurses’ Register Book, where the fifteen-minute nursing observations were recorded.

There were weekly team meetings, where all matters clinical and administrative were discussed. For these meetings, the unit staff were joined by the consultant psychiatrist and his multi-disciplinary team (registrar, psychologist and physiotherapist) and also the assistant matron. The staff at the unit greatly appreciated these meetings as they allowed all care staff to make valuable contributions. This contributed to the high staff morale which was quite evident in the unit. The standards of care, hygiene and décor were of a high order.

PALMERSTOWN VIEW, STEWART’S HOSPITAL
— SECOND 2002 INSPECTION

INSPECTED ON 9 DECEMBER 2002

GENERAL COMMENTS

Unit 22 was a single-storey unit on the Stewart’s Hospital complex. It was locked and reserved for “difficult to manage” or aggressive patients. All patients at the time of inspection were voluntary. Staffing consisted of two nursing staff and two care assistants, together with a household staff member. There was one care assistant at night. All patients went to communal activities in the centre provided for this purpose during the day, provided they were well enough. Some had their meals there and others dined in the unit. No major change occurred in the unit since the last visit of inspection. Generally, physical conditions, decoration and furnishings were satisfactory. Seclusion was used and episodes occurred fairly frequently. There had been twenty-two episodes of seclusion, involving four patients, but mainly two particular individuals since 1st September. Seclusion was prescribed, proactively for the most part, but documented retrospectively, both in medical and nursing case notes. Junior doctors signed the seclusion book usually retrospectively and occasionally by a consultant. Seclusion authorisation was usually for short periods and nursing observations were recorded by fifteen-minute observations. The seclusion room

itself was rather bare, uncladded and appeared to have no heating. At the time of inspection, a patient was secluded; on visiting the room and speaking with the patient it was found that the room was cold. The Inspectorate would be of the opinion that the seclusion room overall should be upgraded. The room was also monitored by closed circuit television.

LARCH VILLA, BELMONT PARK HOSPITAL, WATERFORD

— FIRST 2002 INSPECTION

INSPECTED ON 9 JUNE, 2002

GENERAL DESCRIPTION OF THE SERVICE

Larch Villa was one of four similar bungalows on the campus of Belmont Hospital, but was the only one that fell within the remit of the Inspectorate as it was an approved institution under the mental treatment legislation.

IN-PATIENT CARE

In-patient care was provided at Larch Bungalow where eight beds provided for the mental health needs of persons with intellectual disabilities.

Age and Length of Stay of all Patients at 31.12.01

Length of Stay	Age							
	Under 16	16-19	20-44	45-64	65-74	75 and over	All Ages	% of Total
Less than 3 Months	—	—	1	—	—	—	1	12.5
3 to 12 Months	—	—	1	—	—	—	1	12.5
1 to 5 Years	—	—	1	1	—	—	2	25.0
Over 5 Years	—	—	2	2	—	—	4	50.0
All Lengths of Stay	—	—	5	3	—	—	8	100
% of Total	—	—	62.5	37.5	—	—	100	

In-Patient Population Diagnosis (31.12.01)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	—	—	—	—	—
Personality Disorder	Alcoholic Disorders	Drug Dependence	Intellectual Disability	Unspecified	All Diagnosis
—	—	—	8	—	8

Status of In-Patients on the date of first inspection 2002

Status	Male	Female	Total
Voluntary	6	2	8
Temporary	—	—	—
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	6	2	8

ADMISSIONS/DISCHARGES AND DEATHS IN 2001

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

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of Persons Attending in 2001
Day Hospitals	—	—	—
Day Centres	1	34	34*
Out-patient clinics	—	—	—

*Includes seven people from the psychiatric unit and twenty-seven others with intellectual disabilities.

STAFFING

Medical	Administrative	Nursing	Non-Nursing	Other Professional
0.24	0.40	5.5	5.45	0.20

GENERAL COMMENTS

Larch Bungalow had a complement of eight residents, one of whom was in Lourdes with his family at the time of inspection. Of this complement, six were male and two female. The same personnel were present on the last inspection in 2001. One of the residents was lying in his bed listening to his radio, while the remainder were in the sitting room, initially accompanied by two female care staff and later joined by the senior nurse, who had the status of Clinical Nurse Manager II, and a male care staff member, both of whom had accompanied the two residents on their day trip to the town.

Five of the residents had a diagnosis of moderate to severe learning disability, with marked behavioural disorder, while three had a similar learning disability with moderate behavioural disorder. There was no evidence of any behavioural disorder during the time of this visit. Some patients just walked around the unit, while the majority sat contentedly with the care staff. All the patients’ clothing was very clean and tidy and the bed-linen and bathroom towelling, toiletries, etc., were of a similar high standard.

Seven of the eight residents took part in structured activational activities on a Monday to Friday basis in appropriate facilities on campus; the eighth resident remained in the unit or went on walks with a care staff member.

Medical cover was provided by the Medical Director and she was ably assisted by her multi-disciplinary team in providing para-medical services. This team comprised a consultant psychiatrist, social worker, psychologist, recreational therapist, a visiting physiotherapist, and there was also a visiting GP. There were only two admissions to this unit during the year 2001 and they replaced two patients who were transferred to other units on campus.

The fire precautions were satisfactory and lectures and demonstrations were provided on a regular basis in line with the parent hospital programme.

Following the last inspection, a proper seclusion record book was now in operation and relevant seclusion orders had been signed by a member of the consultant staff. While patients were in seclusion — local practice limited these to one-hour periods — fifteen-minute nursing observations were carried out. These observations were not being recorded and the Inspectorate advised that a special record book be acquired for this purpose. For the previous four-week period, there had been eight episodes of seclusion in which three patients were involved.

There was a safety statement book and each care staff member had a copy of it. Patient care plans, known as I.C.P., were utilised here. Accidents, assaults, etc., were recorded on loose leaves and put into relevant patients' charts, with copies sent to management. There were in the year 2001 thirty-four assaults on patients by patients; three of these were regarded as serious and the remainder were inconsequential. There were nineteen assaults on staff by patients, of which four were regarded as serious.

The ambience of the unit was homely and therapeutic and morale amongst the staff was noticeably high.

The continued registration of this unit under the mental treatment legislation was recommended.

LARCH VILLA, BELMONT PARK HOSPITAL, WATERFORD
— SECOND 2002 INSPECTION

INSPECTED ON 12 NOVEMBER, 2002

GENERAL COMMENTS

This was a single-storey bungalow residence in the grounds of Belmont. There were six residents, all intellectually disabled without any major psychiatric disorder. Four were male and two were female and all were voluntary. Their ages ranged from twenty-one years to the early fifties. All were long-stay, although one had recently come in from the community but was long-stay in the service. There was one nurse and three care staff on duty on the average day and one nurse and one care staff usually at night. There was also a household staff. Residents spent their day on the campus but availed of the well-equipped recreation and occupational hall and premises nearby, in addition to going out to various activities. Seclusion was used and there was an average of ten episodes of seclusion each month, usually involving two patients, but a third was less frequently secluded. Seclusion was used sparingly and for brief periods, mainly for “time out” purposes. The visiting clinical officer who visited three times a week signed the seclusion book, and a consultant was available from the local child services. The seclusion room was safe and was under fifteen-minute observation when a resident was secluded. The prescription kardex was in good order but it was noted that entries should be updated more frequently. The sleeping accommodation consisted of two doubles and two single rooms and the premises was in good decorative and furnishing order. Nurses carried pinpoint personal alarms.

APPENDIX 1

Statistics Relating to the Psychiatric Services

APPENDIX 1

TABLE 1.

Number of Patients in Public Psychiatric Hospitals and Units at 31 December 1997-2002 excluding Older Patients and Patients with an Intellectual Disability in De-Designated Wards.

	1997	1998	1999	2000	2001	2002
EASTERN REGIONAL HEALTH AUTHORITY						
St. Brendan's Hospital, Dublin 7	190	181	187	177	160	143
St. Ita's Hospital, Portrane, County Dublin	565	507	501	498	452	422
St. Vincent's Hospital, Fairview, Dublin 3	83	72	72	74	72	61
Psychiatric Unit, Mater Misericordiae Hospital, Dublin 7	14	15	8	17	15	14
Psychiatric Unit, Vergemount, Clonskeagh, Dublin 6	25	25	22	21	19	22
Psychiatric Unit, St. James's Hospital, Dublin 8	48	89	75	51	47	49
Cluain Mhuire Family Centre, Blackrock, County Dublin	26	46	57	41	34	26
Psychiatric Unit, St. Vincent's Hospital, Elm Park, Dublin 4	20	20	12	14	10	6
Psychiatric Unit, James Connolly Memorial Hospital, Blanchardstown, Dublin 15	13	15	15	19	15	17
Newcastle Hospital, County Wicklow	69	73	65	63	66	66
St. Loman's Hospital, Palmerstown, Dublin 20	68	74	25	19	20	18
Psychiatric Unit, Tallaght Hospital ⁽¹⁾	—	—	44	38	38	49
Lakeview Unit, Naas General Hospital, Naas, County Kildare	34	28	23	42	33	20
Central Mental Hospital, Dundrum, Dublin 14	83	84	86	79	83	74
TOTAL	1,238	1,229	1,192	1,153	1,064	987
MIDLAND HEALTH BOARD						
St. Fintan's Hospital, Portlaoise	125	111	91	97	90	81
St. Loman's Hospital, Mullingar	211	192	187	184	181	171
TOTAL	336	303	278	281	271	252
MID-WESTERN HEALTH BOARD						
Clare Mental Health Services ⁽²⁾	203	194	190	187	146	19
Acute Psychiatric Unit, Ennis General Hospital	—	—	—	—	46	51
Psychiatric Unit, Limerick Regional Hospital	40	46	49	53	46	45
St. Joseph's Hospital, Limerick	191	189	187	184	145	153
TOTAL	434	429	426	424	383	268
NORTH-EASTERN HEALTH BOARD						
St. Brigid's Hospital, Ardee	131	130	120	99	94	75
Psychiatric Unit, Our Lady's Hospital, Navan	17	16	15	18	26	22
St. Davnet's Hospital, Monaghan	109	93	81	67	63	60
Psychiatric Unit, Cavan General Hospital	20	21	13	9	11	9
TOTAL	277	260	229	193	194	166
NORTH-WESTERN HEALTH BOARD						
Sligo Mental Health Service, Ballytivnan, County Sligo	83	68	47	59	47	48
St. Conal's Hospital, Letterkenny, County Donegal	68	70	71	36	36	35
Psychiatric Unit, Letterkenny General Hospital	41	53	48	49	50	42
TOTAL	192	191	166	144	133	125

	1997	1998	1999	2000	2001	2002
SOUTH-EASTERN HEALTH BOARD						
St. Dymphna's Hospital, Carlow	109	102	107	95	92	91
St. Canice's Hospital, Kilkenny	122	132	100	107	77	79
St. Luke's Hospital, Clonmel	204	193	187	170	167	159
St. Michael's Unit, Clonmel	45	43	41	50	45	50
St. Otteran's Hospital, Waterford	117	121	120	120	116	109
Psychiatric Unit, Waterford Regional Hospital, Ardkeen	28	34	21	33	41	33
St. Senan's Hospital, Enniscorthy	177	203	186	195	146	159
TOTAL	802	828	762	770	684	680
SOUTHERN HEALTH BOARD						
North Lee Mental Health Services ⁽³⁾	118	106	107	100	119	119
North Cork Mental Health Services ⁽⁴⁾	267	276	232	217	209	187
South Lee Mental Health Services ⁽⁵⁾	88	70	91	85	99	94
Psychiatric Unit, Bantry General Hospital	19	15	13	12	15	11
St. Finan's Hospital, Killarney	227	209	204	179	145	125
Psychiatric Unit, Tralee General Hospital	50	37	38	48	47	47
TOTAL	769	713	685	641	634	583
WESTERN HEALTH BOARD						
St. Brigid's Hospital, Ballinasloe	394	357	323	280	266	270
Psychiatric Unit, U.C.H., Galway	42	46	47	70	42	68
St. Mary's Hospital, Castlebar	200	191	180	170	138	116
Psychiatric Unit, Roscommon County Hospital	14	24	17	13	8	10
TOTAL	650	618	567	533	454	464
OVERALL TOTAL	4,698	4,571	4,305	4,139	3,817	3,525

⁽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, Sarsfied 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, 2002.

	Psychiatric	Intellectual Disability (De-Designated)	Older Persons (De-Designated)
EASTERN REGIONAL HEALTH AUTHORITY			
St. Brendan's Hospital, Dublin 7	143	—	—
St. Ita's Hospital, Portrane, County Dublin	422	—	—
St. Vincent's Hospital, Fairview, Dublin 3	61	—	—
Psychiatric Unit, Mater Misericordiae Hospital, Dublin 7	14	—	—
Psychiatric Unit, Vergemount, Clonskeagh, Dublin 6	22	—	37
Psychiatric Unit, St. James's Hospital, Dublin 8	49	—	—
Cluain Mhuire Family Centre, Blackrock, County Dublin	26	—	—
Psychiatric Unit, St. Vincent's Hospital, Elm Park, Dublin 4	6	—	3
Psychiatric Unit, James Connolly Memorial Hospital, Blanchardstown, Dublin 15	17	—	—
Newcastle Hospital, County Wicklow	66	—	—
St. Loman's Hospital, Palmerstown, Dublin 20	18	—	—
Psychiatric Unit, Tallaght Hospital	49	—	—
Lakeview Unit, Naas General Hospital, Naas, County Kildare	20	—	—
Central Mental Hospital, Dundrum, Dublin 14	74	—	—
TOTAL	987	—	40
MIDLAND HEALTH BOARD			
St. Fintan's Hospital, Portlaoise	81	47	—
St. Loman's Hospital, Mullingar	171	70	—
TOTAL	252	117	—
MID-WESTERN HEALTH BOARD			
Clare Mental Health Services	19	—	—
Acute Psychiatric Unit, Ennis General Hospital	51	—	—
Psychiatric Unit, Limerick Regional Hospital	45	—	—
St. Joseph's Hospital, Limerick	153	—	—
TOTAL	268	—	—
NORTH-EASTERN HEALTH BOARD			
St. Brigid's Hospital, Ardee, County Louth	75	—	—
Psychiatric Unit, Our Lady's Hospital, Navan	22	—	—
St. Davnet's Hospital, Monaghan	60	36	31
Psychiatric Unit, Cavan General Hospital	9	—	—
TOTAL	166	36	31
NORTH-WESTERN HEALTH BOARD			
Sligo Mental Health Service, Ballytivnan, Sligo	48	—	—
St. Conal's Hospital, Letterkenny	35	—	15
Psychiatric Unit, Letterkenny General Hospital	42	—	—
TOTAL	125	—	15
SOUTH-EASTERN HEALTH BOARD			
St. Dymphna's Hospital, Carlow	91	—	—
St. Canice's Hospital, Kilkenny	79	—	—
St. Luke's Hospital, Clonmel	159	—	—
St. Michael's Unit, Clonmel	50	—	—
St. Otteran's Hospital, Waterford	109	—	—
Psychiatric Unit, Waterford Regional Hospital, Ardkeen	33	—	—
St. Senan's Hospital, Enniscorthy	159	27	74
TOTAL	680	27	74

	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⁾	187	9	—
South Lee Mental Health Services ⁽³⁾	94	—	—
Psychiatric Unit, Bantry General Hospital	11	—	—
St. Finan’s Hospital, Killarney	125	28	—
Psychiatric Unit, Tralee General Hospital	47	—	—
TOTAL	583	37	—
WESTERN HEALTH BOARD			
St. Brigid’s Hospital, Ballinasloe	270	—	—
Psychiatric Unit, U.C.H., Galway	68	—	—
St. Mary’s Hospital, Castlebar	116	—	—
Psychiatric Unit, Roscommon County Hospital	10	—	—
TOTAL	464	—	—
OVERALL TOTAL	3,525	217	160

⁽¹⁾ St. Michael’s Unit, Mercy Hospital & Carraig Mor.
⁽²⁾ St. Stephen’s Hospital, Sarsfied 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, 2000-2002.

	2000	2001	2002
EASTERN REGIONAL HEALTH AUTHORITY			
St. Brendan's Hospital, Dublin 7			
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	1.0 ⁽¹⁾	1.0 ⁽¹⁾	0.9 ⁽¹⁾
Cluain Mhuire Family Centre, Blackrock, County Dublin			
Psychiatric Unit, St. Vincent's Hospital, Elm Park, Dublin 4			
Psychiatric Unit, James Connolly Memorial Hospital, Blanchardstown, Dublin 15			
Wicklow Mental Health Services	0.7	0.7	0.7
St. Loman's Hospital, Palmerstown, Dublin 20	0.2	0.4	0.3
Psychiatric Unit, Tallaght Hospital			0.1
Kildare Mental Health Services			
TOTAL	0.7	0.7	0.7
MIDLAND HEALTH BOARD			
Laois/Offaly Mental Health Services	0.9	0.8	0.7
Longford/Westmeath Mental Health Services	1.9	1.9	1.8
TOTAL	1.4	1.3	1.2
MID-WESTERN HEALTH BOARD			
Clare Mental Health Services	2.0	2.0	0.7
Limerick Mental Health Services	1.4	1.2	1.2
TOTAL	1.6	1.5	1.0
NORTH-EASTERN HEALTH BOARD			
Louth/Meath Mental Health Services	0.6	0.6	0.5
Cavan/Monaghan Mental Health Services	0.7	0.7	0.7
TOTAL	0.6	0.6	0.5
NORTH-WESTERN HEALTH BOARD			
Sligo Mental Health Services	0.6	0.6	0.5
Donegal Mental Health Services	0.7	0.7	0.6
TOTAL	0.7	0.6	0.6
SOUTH-EASTERN HEALTH BOARD			
Carlow Mental Health Services	2.3	2.2	2.2
Kilkenny Mental Health Services	1.8	1.3	1.3
Tipperary Mental Health Services	1.6	1.6	1.5
Waterford Mental Health Services	1.4	1.5	1.3
Wexford Mental Health Services	1.9	1.4	1.5
TOTAL	1.7	1.5	1.5

	2000	2001	2002
SOUTHERN HEALTH BOARD			
North Lee Mental Health Services ⁽²⁾	1.1 ⁽¹⁾	1.0 ⁽¹⁾	1.0 ⁽¹⁾
North Cork Mental Health Services ⁽³⁾			
South Lee Mental Health Services ⁽⁴⁾			
West Cork Mental Health Services			
Kerry Mental Health Services	1.8	1.5	1.4
TOTAL	1.2	1.1	1.1
WESTERN HEALTH BOARD			
East Galway Mental Health Services	1.8	1.6	1.8
West Galway Mental Health Services			
Mayo Mental Health Services			
Roscommon Mental Health Services			
TOTAL	1.5	1.3	1.3
OVERALL TOTAL	1.1	1.0	0.9

⁽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⁾ 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, 1999-2001.

	2000	2001	2002	Rates per 1,000 of Population		
				2000	2001	2002
EASTERN REGIONAL HEALTH AUTHORITY						
St. Brendan's Hospital, Dublin 7	914	668	590	5.1 ⁽¹⁾	5.2 ⁽¹⁾	4.7 ⁽¹⁾
St. Ita's Hospital, Portrane, County Dublin	917	894	792			
St. Vincent's Hospital, Fairview, Dublin 3	714	719	653			
Psychiatric Unit, Mater Misericordiae Hospital, Dublin 7	238	240	228			
Psychiatric Unit, Vergemount, Clonskeagh, Dublin 6	451	346	333			
Psychiatric Unit, St. James's Hospital, Dublin 8 ⁽²⁾	428	468	557			
Cluain Mhuire Family Centre, Blackrock, County Dublin	417	417	386			
Psychiatric Unit, St. Vincent's Hospital, Elm Park, Dublin 4	373	284	169	6.7	6.5	5.5
Psychiatric Unit, James Connolly Memorial Hospital, Blanchardstown, Dublin 15	250	302	261			
Newcastle Hospital, County Wicklow	598	582	495			
St. Loman's Hospital, Palmerstown, Dublin 20	55	40	—			
Psychiatric Unit, Tallaght Hospital	627	660	620	2.9	3.0	2.4
Lakeview Unit, Naas General Hospital, Naas, County Kildare	610	719	727			
TOTAL	6,592	6,339	5,811	4.6	4.7	4.3
MIDLAND HEALTH BOARD						
St. Fintan's Hospital, Portlaoise	736	768	688	6.6	6.9	6.1
St. Loman's Hospital, Mullingar	807	844	795	8.5	8.9	8.4
TOTAL	1,543	1,612	1,483	7.5	7.8	7.2
MID-WESTERN HEALTH BOARD						
Clare Mental Health Services	507	502	518	5.4	5.3	5.5
Psychiatric Unit, Limerick Regional Hospital	769	761	712			
St. Joseph's Hospital, Limerick	10	7	10			
TOTAL	1,286	1,270	1,240	5.0	4.9	4.8
NORTH-EASTERN HEALTH BOARD						
St. Brigid's Hospital, Ardee	430	420	428	3.5	3.6	3.5
Psychiatric Unit, Our Lady's Hospital, Navan	280	308	277			
St. Davnet's Hospital, Monaghan	66	68	59	2.2	2.0	1.9
Psychiatric Unit, Cavan General Hospital	158	136	134			
TOTAL	934	932	898	3.1	3.1	3.0

	2000	2001	2002	Rates per 1,000 of Population			
				2000	2001	2002	
NORTH-WESTERN HEALTH BOARD							
Sligo Mental Health Service, Ballytivnan	574	690	532	}	6.2	7.5	5.8
St. Conal's Hospital, Letterkenny Psychiatric Unit, Letterkenny General Hospital	—	—	—		6.6	7.6	6.4
	803	921	780				
TOTAL	1,377	1,611	1,312		6.5	7.5	6.1
SOUTH-EASTERN HEALTH BOARD							
St. Dympna's Hospital, Carlow	315	296	289	}	7.6	7.1	6.9
St. Canice's Hospital, Kilkenny	385	411	417		6.4	6.8	6.9
St. Luke's Hospital, Clonmel ⁽³⁾	174	129	205		9.2	8.3	8.1
St. Michael's Unit, Clonmel ⁽³⁾	1,079	990	897	}			
St. Otteran's Hospital, Waterford Psychiatric Unit, Waterford Regional Hospital, Ardkeen	49	43	19		7.5	7.3	7.4
	755	737	768				
St. Senan's Hospital, Enniscorthy	546	585	617		5.3	5.6	5.9
TOTAL	3,303	3,191	3,212		7.4	7.1	7.2
SOUTHERN HEALTH BOARD							
North Lee Mental Health Services ⁽⁴⁾	1,030	1,171	1,123	}	6.1 ⁽¹⁾	5.8 ⁽¹⁾	5.7 ⁽¹⁾
North Cork Mental Health Services ⁽⁵⁾	523	349	364				
South Lee Mental Health Services ⁽⁶⁾	688	678	658				
Psychiatric Unit, Bantry General Hospital	349	276	265	}	7.0	7.1	6.7
St. Finan's Hospital, Killarney Psychiatric Unit, Tralee General Hospital	61	60	62				
	820	837	787				
TOTAL	3,471	3,371	3,259		6.3	6.1	5.9
WESTERN HEALTH BOARD							
St. Brigid's Hospital, Ballinasloe ⁽⁷⁾ Psychiatric Unit, U.C.H., Galway	708	655	741	}	7.6	7.8	7.2
	745	834	648				
St. Mary's Hospital, Castlebar Psychiatric Unit, Roscommon County Hospital	628	664	600		5.7	6.0	5.4
	446	449	387		8.5	8.5	7.3
TOTAL	2,527	2,602	2,376		7.1	7.3	6.7
OVERALL TOTAL	21,033	20,928	19,591		5.6	5.7	5.3

⁽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, Sarsfied 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, 2002.

	Number of Community Residences	Number of Places	Places per 100,000 Population	Catchment Area Pop.
EASTERN REGIONAL HEALTH AUTHORITY				835,734
St. Brendan's Hospital, Dublin 7	9	88	} 64	129,000
Psychiatric Unit, James Connolly Memorial Hospital	10	125		
St. Ita's Hospital, Portrane, County Dublin	16	114		202,157
St. Vincent's Hospital, Fairview, Dublin 3/ Psychiatric Unit, Mater Misericordiae Hospital, Dublin 7	7	74		138,000
Psychiatric Unit, Vergemount, Clonskeagh, Dublin 6	3	35		99,577
Psychiatric Unit, St. James's Hospital, Dublin 8	7	47		97,000
Cluain Mhuire Family Centre, Blackrock, County Dublin	5	50		170,000
Newcastle Hospital, County Wicklow	9	82	91	89,713
St. Loman's Hospital, Palmerstown, Dublin 20	13	117	45	258,028
Lakeview Unit, Naas General Hospital, Naas, County Kildare	6	52	30	171,000
TOTAL	85	784	58	1,354,475
MIDLAND HEALTH BOARD				
Laois/Offaly Mental Health Services	17	111	99	111,878
Longford/Westmeath Mental Health Services	12	89	93	95,200
TOTAL	29	200	97	207,078
MID-WESTERN HEALTH BOARD				
Clare Mental Health Services	19	220	234	94,006
Limerick Mental Health Services	15	146	88	165,042
TOTAL	34	366	141	259,048
NORTH-EASTERN HEALTH BOARD				
Louth/Meath Mental Health Services	8	97	48	200,074
Cavan/Monaghan Mental Health Services	16	105	102	103,000
TOTAL	24	202	67	303,074
NORTH-WESTERN HEALTH BOARD				
Sligo/Leitrim Mental Health Services	24	173	188	92,000
Donegal Mental Health Services	17	122	100	121,412
TOTAL	41	295	138	213,412
SOUTH-EASTERN HEALTH BOARD				
Carlow Mental Health Services	8	65	156	41,597
Kilkenny Mental Health Services	14	121	201	60,300
Tipperary Mental Health Services	15	80	59	135,620
Waterford Mental Health Services	16	98	92	106,529
Wexford Mental Health Services	14	81	78	104,371
TOTAL	67	445	99	448,417

	Number of Community Residences	Number of Places	Places per 100,000 Population	Catchment Area Pop.
SOUTHERN HEALTH BOARD				425,488
North Lee Mental Health Services ⁽²⁾	6	53	} 47 ⁽¹⁾	145,233
North Cork Mental Health Services ⁽³⁾	4	26		75,690
South Lee Mental Health Services ⁽⁴⁾	8	41		156,340
West Cork Mental Health Services ⁽⁵⁾	9	81		48,225
Kerry Mental Health Services ⁽⁶⁾	17	140	111	126,130
TOTAL	44	341	62	551,618
WESTERN HEALTH BOARD				
East Galway Mental Health Services	49	265	} 169	91,619
West Galway Mental Health Services	11	59		100,000
Mayo Mental Health Services	20	122		111,000
Roscommon Mental Health Services	7	67		52,726
TOTAL	87	513	144	355,345
OVERALL TOTAL	411	3,146	85	3,692,467

⁽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, Sarsfied 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, 1999-2002.

	1999	2000	2001	2002
Bloomfield Hospital, Dublin	38	44	36	43
Palmerstown View, Stewart's Hospital, Dublin	6	4	4	5
Hampstead and Highfield Hospitals, Dublin	73	71	80	78
Kylemore Clinic, Dun Laoghaire/Rathdown	38	37	37	37
Larch Bungalow, Belmont Park, Waterford	6	7	8	8
St. John of God Hospital, Dun Laoghaire/ Rathdown	91	87	83	94
St. Patrick's Hospital, Dublin (inc. St. Edmundsbury)	169	133	191	176
TOTAL	421	383	439	441

INSPECTORATE OF MENTAL HOSPITALS

SECLUSION RECORD 2002

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	905	92
St. Ita's Hospital	81	32
St. Joseph's Mental Handicap Services	138	19
St. Vincent's Hospital, Fairview, Dublin 3	41	17
Psychiatric Unit, Mater Misericordiae Hospital, Dublin 7	20	7
Psychiatric Unit, James Connolly Memorial Hospital, Blanchardstown, Dublin 15	0	0
Total	1,185	167

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	138	16
Central Mental Hospital	644	60
St. John of God, Stillorgan & Area Service 1	109	23
Psychiatric Unit, St. Vincent's Hospital, Elm Park, Dublin 4	0	0
Total	891	99

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	26	9
Kildare MHS Lakeview Unit	83	15
St. Patrick's Hospital & St. Edmundsbury	0	0
Hampstead Private	0	0
Total	109	24

MIDLAND HEALTH BOARD

Hospital & In-Patient Unit	No. of Episodes of Seclusion	No. of Patients Placed in Seclusion
St. Fintan's Hospital, Portlaoise	41	14
St. Loman's Hospital, Mullingar	2	2
Total	43	16

MID-WESTERN HEALTH BOARD

Hospital & In-Patient Unit	No. of Episodes of Seclusion	No. of Patients Placed in Seclusion
Clare Mental Health Services	98	28
Limerick Mental Health Services	9	2
Total	107	30

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	93	16
St. Davnet’s Hospital, Monaghan	0	0
Psychiatric Unit, Cavan General Hospital	0	0
Total	93	16

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	23	13
St. Conal’s, Letterkenny, County Donegal	0	0
Psychiatric Unit, Letterkenny General Hospital	0	0
Total	23	13

SOUTH EASTERN HEALTH BOARD

Hospital & In-Patient Unit	No. of Episodes of Seclusion	No. of Patients Placed in Seclusion
St. Dympna’s Hospital, Carlow	1,318	2
St. Canice’s Hospital, Kilkenny	46	2
St. Luke’s Hospital, Clonmel	350	34
St. Michael’s Unit, Clonmel	104	51
St. Otteran’s Hospital, Waterford	13	2
Psychiatric Unit, Waterford Regional Hospital, Ardkeen	23	13
St. Senan’s Hospital, Enniscorthy	34	5
Total	1,888	109

SOUTHERN HEALTH BOARD

Hospital & In-Patient Unit	No. of Episodes of Seclusion	No. of Patients Placed in Seclusion
North Lee Mental Health Service ⁽¹⁾	1	1
North Cork Mental Health Service ⁽²⁾	0	0
South Lee Mental Health Service ⁽³⁾	0	0
Psychiatric Unit, Bantry General Hospital	0	0
St. Finan’s Hospital, Killarney	32	8
Psychiatric Unit, Tralee General Hospital	41	10
Total	74	19

WESTERN HEALTH BOARD

Hospital & In-Patient Unit	No. of Episodes of Seclusion	No. of Patients Placed in Seclusion
St. Bridget’s Hospital, Ballinasloe	152	5
University College Hospital, Galway	0	0
St. Mary’s Hospital, Castlebar	317	1
Psychiatric Unit, Roscommon County Hospital	0	0
Total	469	6

	No. of Episodes of Seclusion	No. of Patients Placed in Seclusion
Midland Health Board	43	16
Mid-Western Health Board	107	30
North Eastern Health Board	93	16
North Western Health Board	23	13
South Eastern Health Board	1,888	109
Southern Health Board	74	19
Western Health Board	469	6
Eastern Regional Health Authority	2,185	290
Total	4,882	499

⁽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.

N/A Not available from the Service Provider.

INSPECTORATE OF MENTAL HOSPITALS

PRESCRIPTION OF ELECTRO CONVULSIVE THERAPY — NUMBER OF PATIENTS — 2002

EASTERN REGIONAL HEALTH AUTHORITY

NORTHERN AREA HEALTH BOARD

Hospital & In-Patient Unit	E.C.T.
St. Brendan's Hospital	10
St. Ita's Hospital	33
St. Joseph's Mental Handicap Services	0
St. Vincent's Hospital, Fairview, Dublin 3	15
Psychiatric Unit, Mater Misericordiae Hospital, Dublin 7	10
Psychiatric Unit, James Connolly Memorial Hospital, Blanchardstown, Dublin 15	20
Total	88

EAST COAST AREA HEALTH BOARD

Hospital & In-Patient Unit	E.C.T.
Psychiatric Unit, Vergemount, Clonskeagh, Dublin 6	14
Newcastle Hospital, Co. Wicklow	29
Central Mental Hospital	0
St. John of God, Stillorgan & Area Service 1	11
Psychiatric Unit, St. Vincent's Hospital, Elm Park, Dublin 4	5
Total	59

SOUTH WESTERN HEALTH BOARD

Hospital & In-Patient Unit	E.C.T.
St. James's Hospital	9
St. Loman's Hospital, Palmerstown, Dublin 20	0
Psychiatric Unit, Tallaght Hospital	29
Kildare MHS Lakeview Unit	126
St. Patrick's Hospital & St. Edmundsbury	149
Hampstead Private	38
Total	351

MIDLAND HEALTH BOARD

Hospital & In-Patient Unit	E.C.T.
St. Fintan's Hospital, Portlaoise	5
St. Loman's Hospital, Mullingar	14
Total	19

MID-WESTERN HEALTH BOARD

Hospital & In-Patient Unit	E.C.T.
Clare Mental Health Services	6
Limerick Mental Health Services	41
Total	47

NORTH EASTERN HEALTH BOARD

Hospital & In-Patient Unit	E.C.T.
St. Brigid’s Hospital, Ardee	17
Psychiatric Unit, Our Lady’s Hospital, Navan	6
St. Davnet’s Hospital, Monaghan	2
Psychiatric Unit, Cavan General Hospital	8
Total	33

NORTH-WESTERN HEALTH BOARD

Hospital & In-Patient Unit	E.C.T.
Sligo Mental Health Service, Ballytivan, County Sligo	8
St. Conal’s, Letterkenny, County Donegal	0
Psychiatric Unit, Letterkenny General Hospital	14
Total	22

SOUTH EASTERN HEALTH BOARD

Hospital & In-Patient Unit	E.C.T.
St. Dympna’s Hospital, Carlow	0
St. Canice’s Hospital, Kilkenny	14
St. Luke’s Hospital, Clonmel	2
St. Michael’s Unit, Clonmel	31
St. Otteran’s Hospital, Waterford	
Psychiatric Unit, Waterford Regional Hospital, Ardkeen	144
	(includes St. Otteran’s)
St. Senan’s Hospital, Enniscorthy	22
Total	213

SOUTHERN HEALTH BOARD

Hospital & In-Patient Unit	E.C.T.
North Lee Mental Health Service ⁽¹⁾	4
North Cork Mental Health Service ⁽²⁾	9
South Lee Mental Health Service ⁽³⁾	12
Psychiatric Unit, Bantry General Hospital	0
St. Finan’s Hospital, Killarney	0
Psychiatric Unit, Tralee General Hospital	17
Total	42

WESTERN HEALTH BOARD

Hospital & In-Patient Unit	E.C.T.
St. Bridget’s Hospital, Ballinasloe	64
University College Hospital, Galway	29
St. Mary’s Hospital, Castlebar	45
Psychiatric Unit, Roscommon County Hospital	9
Total	147

Health Board	E.C.T.
Eastern Regional Health Authority	498
Midland Health Board	19
Mid-Western Health Board	47
North Eastern Health Board	33
North Western Health Board	22
South Eastern Health Board	213
Southern Health Board	42
Western Health Board	147
Total	1,021

⁽¹⁾ St. Michael’s Unit, Mercy Hospital & Carraig Mor.
⁽²⁾ St. Stephen’s Hospital, Sarsfied Court.
⁽³⁾ Psychiatric Unit, Cork University Hospital & St. Finbarr’s Hospital.
N/A Not available from the Service Provider.

INSPECTORATE OF MENTAL HOSPITALS		
SPECIAL NURSING RECORD 2002		
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	736	28
St. Ita's Hospital	146	5
St. Joseph's Mental Handicap Services	382	2
St. Vincent's Hospital, Fairview, Dublin 3	0	0
Psychiatric Unit, Mater Misericordiae Hospital, Dublin 7	19	11
Psychiatric Unit, James Connolly Memorial Hospital, Blanchardstown, Dublin 15	1,244	78
Total	2,527	124
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	538	53
Newcastle Hospital, Co. Wicklow	19	16
Central Mental Hospital	0	0
St. John of God, Stillorgan & Area Service 1	0	0
Psychiatric Unit, St. Vincent's Hospital, Elm Park, Dublin 4	197	15
Total	754	84
SOUTH WESTERN HEALTH BOARD		
Hospital & In-Patient Unit	Spans of Special Nursing	No. of Patients on Special Nursing
St. James's Hospital	161	15
St. Loman's Hospital, Palmerstown, Dublin 20	0	0
Psychiatric Unit, Tallaght Hospital	582	32
Kildare MHS Lakeview Unit	540	14
St. Patrick's Hospital & St. Edmundsbury	0	0
Hampstead Private	0	0
Total	1,283	46
MIDLAND HEALTH BOARD		
Hospital & In-Patient Unit	Spans of Special Nursing	No. of Patients on Special Nursing
St. Fintan's Hospital, Portlaoise	98	7
St. Loman's Hospital, Mullingar	413	12
Total	511	19
MID-WESTERN HEALTH BOARD		
Hospital & In-Patient Unit	Spans of Special Nursing	No. of Patients on Special Nursing
Clare Mental Health Services	93	27
Limerick Mental Health Services	2,680	N/A
Total	2,773	27

NORTH EASTERN HEALTH BOARD

Hospital & In-Patient Unit	Spans of Special Nursing	No. of Patients on Special Nursing
St. Brigid’s Hospital, Ardee	243	4
Psychiatric Unit, Our Lady’s Hospital, Navan	554	9
St. Davnet’s Hospital, Monaghan	6	3
Psychiatric Unit, Cavan General Hospital	58	4
Total	861	20

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	497	35
St. Conal’s, Letterkenny, County Donegal	0	0
Psychiatric Unit, Letterkenny General Hospital	787	35
Total	1,284	70

SOUTH EASTERN HEALTH BOARD

Hospital & In-Patient Unit	Spans of Special Nursing	No. of Patients on Special Nursing
St. Dympna’s Hospital, Carlow	374	11
St. Canice’s Hospital, Kilkenny	41	12
St. Luke’s Hospital, Clonmel	333	12
St. Michael’s Unit, Clonmel	157	18
St. Otteran’s Hospital, Waterford	3	1
Psychiatric Unit, Waterford Regional Hospital, Ardkeen	8	4
St. Senan’s Hospital, Enniscorthy	346	13
Total	1,262	71

SOUTHERN HEALTH BOARD

Hospital & In-Patient Unit	Spans of Special Nursing	No. of Patients on Special Nursing
North Lee Mental Health Service ⁽¹⁾	548	30
North Cork Mental Health Service ⁽²⁾	901	53
South Lee Mental Health Service ⁽³⁾	645	27
Psychiatric Unit, Bantry General Hospital	150	6
St. Finan’s Hospital, Killarney	96	9
Psychiatric Unit, Tralee General Hospital	N/A	N/A
Total	2,340	125

WESTERN HEALTH BOARD

Hospital & In-Patient Unit	Spans of Special Nursing	No. of Patients on Special Nursing
St. Bridget’s Hospital, Ballinasloe	610	46
University College Hospital, Galway	762	35
St. Mary’s Hospital, Castlebar	847	6
Psychiatric Unit, Roscommon County Hospital	154	20
Total	2,373	107

	Spans of Special Nursing	No. of Patients on Special Nursing
Eastern Regional Health Authority	4,564	254
Midland Health Board	511	19
Mid-Western Health Board	2,773	27
North Eastern Health Board	861	20
North Western Health Board	1,284	70
South Eastern Health Board	1,262	71
Southern Health Board	2,340	125
Western Health Board	2,373	107
Total	15,968	693

⁽¹⁾ St. Michael's Unit, Mercy Hospital & Carraig Mor.
⁽²⁾ St. Stephen's Hospital, Sarsfied Court.
⁽³⁾ Psychiatric Unit, Cork University Hospital & St. Finbarr's Hospital.

N/A Not available from the Service Provider.

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	81	90	14	13	1
St. Ita's Hospital	73	54	13	7	0
St. Joseph's Mental Handicap Services	0	0	0	0	0
St. Vincent's Hospital, Fairview, Dublin 3	109	23	7	7	0
Psychiatric Unit, Mater Misericordiae Hospital, Dublin 7	27	0	3	0	0
Psychiatric Unit, James Connolly Memorial Hospital, Blanchardstown, Dublin 15	29	1	0	0	0
Total	319	168	37	27	1

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	35	0	7	2	0
Newcastle Hospital, Co. Wicklow	50	4	8	4	0
Central Mental Hospital	94	0	0	0	0
St. John of God, Stillorgan & Area Service 1	54	5	14	0	0
Psychiatric Unit, St. Vincent's Hospital, Elm Park, Dublin 4	4	0	1	0	0
Total	237	9	30	6	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	51	0	0	0	0
St. Loman's Hospital, Palmerstown, Dublin 20	0	0	0	0	0
Psychiatric Unit, Tallaght Hospital	78	8	10	10	0
Kildare MHS Lakeview Unit	124	152	0	10	3
St. Patrick's Hospital & St. Edmundsbury	50	0	0	0	0
Hampstead Private	0	0	0	0	0
Total	303	160	10	20	3

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	53	0	10	19	0
St. Loman's Hospital, Mullingar	92	14	11	15	0
Total	145	14	21	34	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	72	0	13	11	0
Limerick Mental Health Services	105	7	17	17	15
Total	177	7	30	28	15

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	50	18	16	26	8
Psychiatric Unit, Our Lady’s Hospital, Navan	30	1	15	9	0
St. Davnet’s Hospital, Monaghan	11	1	0	3	1
Psychiatric Unit, Cavan General Hospital	24	3	4	0	0
Total	115	23	35	38	9

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	40	10	15	29	24
St. Conal’s, Letterkenny, County Donegal	0	0	0	0	0
Psychiatric Unit, Letterkenny General Hospital	91	6	29	23	0
Total	131	16	44	52	24

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. Dympna’s Hospital, Carlow	14	12	4	1	0
St. Canice’s Hospital, Kilkenny	34	4	3	5	0
St. Luke’s Hospital, Clonmel	46	4	3	4	0
St. Michael’s Unit, Clonmel	122	2	20	31	0
St. Otteran’s Hospital, Waterford	4	0	1	4	0
Psychiatric Unit, Waterford Regional Hospital, Ardkeen	53	9	4	7	0
St. Senan’s Hospital, Enniscorthy	64	5	1	1	0
Total	337	36	36	53	0

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 ⁽¹⁾	207	8	20	47	0
North Cork Mental Health Service ⁽²⁾	25	7	13	13	0
South Lee Mental Health Service ⁽³⁾	148	2	33	116	0
Psychiatric Unit, Bantry General Hospital	23	0	10	16	1
St. Finan’s Hospital, Killarney	41	11	1	0	0
Psychiatric Unit, Tralee General Hospital	111	0	21	10	0
Total	555	28	98	202	1

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. Bridget's Hospital, Ballinasloe	80	9	11	38	59
University College Hospital, Galway	77	0	28	7	0
St. Mary's Hospital, Castlebar	97	6	26	31	4
Psychiatric Unit, Roscommon County Hospital	36	0	9	7	5
Total	290	15	74	83	68

Hospital & In-Patient Unit	No. Temp Admiss	No. Temp Extns	No. Vol Regrad	No. Invol Regrad	No. P.U.M. Admiss
Midland Health Board	145	14	21	34	0
Mid-Western Health Board	177	7	30	28	15
North Eastern Health Board	115	23	35	38	9
North Western Health Board	131	16	44	52	24
South Eastern Health Board	337	36	36	53	0
Southern Health Board	555	28	98	202	1
Western Health Board	290	15	74	83	68
Eastern Regional Health Authority	859	337	77	53	4
Total	2,609	476	415	543	121

⁽¹⁾ St. Michael's Unit, Mercy Hospital & Carraig Mor.
⁽²⁾ St. Stephen's Hospital, Sarsfied Court.
⁽³⁾ Psychiatric Unit, Cork University Hospital & St. Finbarr's Hospital.

N/A Not available from the Service Provider.

APPENDIX 2

Procedures Checklist

INSPECTORATE OF MENTAL HOSPITALS
HOSPITAL & SERVICE CHECKLIST

CONSUMER INFORMATION AND TRANSPARENCY

Introduction and Identification

- The patient should be introduced to the professional team responsible for his/her care.
- Patient should know treating consultant and have reasonable access to consultant and members of the multi-disciplinary team.
- Patients should have a right to meet with their treating consultant.
- Staff members should wear identity badges, indicating designation within multidisciplinary team.
- On request all staff should be available for patients and relatives within a reasonable time.
- Staff should identify themselves to the patient as soon as any professional or clinical interaction takes place.

The Treatment Plan

- Patients should be informed of diagnosis and provided with suitable information and literature on their condition in all appropriate circumstances.
- Treatment plans should be discussed with patients.
- Treatment plans, including medication, should be clearly recorded in patients' case notes.
- The nature of treatment and medication should be explained to patients in language they understand.
- Written information should be available to patients on prescribed medication relating to its effects and side effects.
- Patients should be given reasonable time to consider treatment plans and medication, and have the opportunity to discuss treatment plans with relatives if required.
- Patients should be made aware of voluntary self help groups relevant to their illness and how to access them.

Consumer/Complaints

- A written procedure for dealing with complaints from patients and families should be available. Patients should be made aware of its existence and how to use it.
- Patients should be encouraged to make a complaint (verbal or written) to the local service if they feel aggrieved or dissatisfied.
- Notices to this effect should be prominently displayed at every treatment location with the name of the local complaints officer.
- A handbook containing information on complaints procedure and patients' rights to learn about his/her treatment plan and medication should be available for patients' and relatives' information and reference.
- Written procedures for dealing with complaints from patients and relatives should be available in each local service.
- This written procedure on complaints should indicate the level of authority expected to deal with complaints.
- There should be a specific register for the recording of complaints with a designated complaints officer maintaining this record.
- There should be a consistent approach to recording and investigating of complaints.
- There should be written guidelines on complaints alleging abuse and ill treatment of patients.
- These guidelines should be known to staff members and available on request to patients and families.

Protection of the Consumer — Mental Health Legislation

- There should be written information for patients and relatives on their rights under the Mental Treatment Act, 1945 and amending legislation.
- Patients should be cared for in the least restrictive environment possible.
- Patients should be informed of their right of appeal when they are not satisfied with the local complaints procedure.
- Patients should be able to access care and treatment as near as possible to their homes.
- There should be full information on care and treatment available to the patient and if appropriate his/her relatives if the patient agrees.
- Patients should have informed consent and be aware of their rights in relation to refusal of treatment.
- Patients should have access to specialised treatments and spiritual care as appropriate.
- Patients should have a right to change their treating psychiatrist within the catchment area team.

Research

- All patient participation in clinical trials should be in accordance with clinical trials legislation.
- There should be a representative and properly constituted ethics committee which approves all clinical trials.
- Formal written informed consent of the patient should be unequivocally obtained before the participation of the patient in any clinical trial.

The Product/Process/Partners in Care

- There should be a diagnosis and step-by-step treatment and care plan for each patient.
- Treatment plans for patients should be decided at multidisciplinary meetings whether in in-patient or community-based settings.
- Multi-disciplinary team meetings should be informed by a full case presentation involving psychiatric, nursing, psychological and social inputs leading to a diagnosis and definitive action care plan.
- All care planning should be adequately recorded in medical case notes.
- Nurse care planning should evolve on an agreed model of nursing care with specific goals, target dates and review dates.
- The nurse care planning system should commence with a nursing assessment covering all aspects of patient care, physical, psychological and social.
- Care plans should incorporate specific problems such as disturbed behaviour and where appropriate, physical nursing care.
- Risk assessment in areas of pressure sores and infection control should be included in the care plan as appropriate.
- Medical, paramedical and nursing care plans should be clearly documented in the appropriate section of the case file and entries signed in full with date and time.
- Family members should have the opportunity to discuss a patient's care and treatment with the consultant and members of the multidisciplinary team subject to the patient's agreement.
- Family members should have access to advice and information on all aspects of the patient's illness and treatment prognosis and caring arrangements if the patient agrees.
- Subject to the patient's agreement, carers should have a right to all possible information concerning the patient's illness and its treatment and should be put in touch with voluntary and self-help groups when that is deemed appropriate.
- Relatives should be made aware of their right to complain and their rights of external appeal under current mental health legislation.

The Right to Privacy

- Interviews between patients and relatives and mental health staff should be effected in settings which provide privacy.

THE PROCESS

Admission to In-patient Care

- A fully documented admission policy and procedure document should be available in each service.
- Admission decisions should generally be made by consultant psychiatrists.
- Decisions to admit patients involuntarily should be the exclusive right of consultant psychiatrists and they alone should complete temporary patient reception orders.
- The physical surroundings in the admission/reception area for patients should be reassuring, comfortable and private.
- Patients indicating a willingness to remain in hospital and giving no indication of wanting to leave should be asked to enter hospital as a voluntary patient.
- All necessary information relating to a patient's stay in hospital, their rights under the Mental Treatment Act, 1945 and amending legislation, should be transmitted to the patient and to their relatives, where appropriate, at the time of admission.

Clinical Review

- Involuntary patients should have their status changed to voluntary as soon as it is deemed appropriate.
- All newly admitted patients should be clinically reviewed on a daily basis and the results of such review documented clearly in the case notes.
- All entries by professional staff in clinical documentation should be signed legibly and in full with the designation of the professional staff member stated.
- There should be a written policy on the care of patients' case notes.
- Administrative and biographical details (name, address, date of birth etc.) should be completed in full for each admission.
- A section of this form should contain information relating to discharge date, final diagnosis on discharge and this should be completed in full.
- Individual patient case records should contain information on the following:—
 - History of the illness for which the patient is being treated, personal history of the patient, patient's family history.
 - Diagnosis, legal status of the patient.
 - Particulars of medical examination on reception and all reviews, changes in the mental condition of the patient, any unusual occurrences, absence on leave/parole/pass.
 - Date of discharge, assessment prior to discharge and in the case of death, the cause of death.
- Correspondence and investigation reports should be correctly filed in chronological order and copies of previous discharge summaries should be readily available in case notes.
- All professional progress notes (e.g. social worker, psychologist, occupational therapist) should be completed by such staff and readily accessible in patients' care records.

Medical Preparations

- There should be a written policy for the ordering, prescribing, storing and administering of medicines.
- The medical preparations policy should be signed, dated with an appropriate review date and available in each clinical area for information and reference.
- The medical preparations policy and procedure should contain information on staff responsibility relating to ordering drugs, storage and checking drug stocks, administering drugs, mode of administration and information on drugs given to patients on discharge.

- There should be written instructions for the use of prescription cards with one signature and one date for each prescription.
- The discontinuation column of the prescription card should have one signature and one date for each prescription.
- The drug administration recording card should have provision for a nurse's signature in full.
- There should be written guidelines for the use of (PRN) medications. Medication prescribed to be given whenever necessary rather than at fixed times.

Electro Convulsive Therapy (ECT)

- This procedure should only be administered to patients with their fully informed written consent.
- There should be a written protocol for the administration of ECT.
- Guidelines for the administration of ECT should be displayed prominently in the treatment room including a pre and post ECT nursing check list.
- A named consultant psychiatrist should be responsible for the ECT programme and oversee its administration.
- There should be a specific ECT treatment record form incorporating the consent form.
- The treatment facilities for ECT should incorporate waiting, treatment and recovery rooms.
- Adequate monitoring and resuscitation equipment should be available in each treatment unit.
- The administration and clinical response to ECT should be documented clearly in patients' case notes.
- All staff working in the service should have regular cardio-pulmonary resuscitation and foreign body airway obstruction training.

Primary Nursing in the Hospital Setting

- Each patient should be allocated a nurse directly responsible for the patient's care at ward level on a day to day basis.
- The nurse in charge should determine the number of patients for whom each primary nurse should have direct responsibility.
- The assigned primary nurse should have responsibility for nursing care plan documentation and for the presentation of clinical aspects of the patient's condition at multi-disciplinary review meetings.

Seclusion and Restraint

- Where seclusion occurs there should be a clear written seclusion policy including the definition of seclusion with relevant extracts from the Mental Treatment Act, 1945 and amending legislation.
- A separate nursing seclusion care plan for the patient should be introduced once a patient is placed in seclusion.
- Seclusion should only be prescribed in writing by a consultant psychiatrist and should be reviewed on a six hourly basis.
- In the rare instances mechanical restraint is used, the same procedures should apply.
- A seclusion register should be maintained and the fifteen minute nursing observation should be fully documented.

Persons detained under Reception Orders

- The patient must be involved in the decision relating to absence on trial and must consent to any consultation with relatives relating thereto.
- Decisions relating to absence on parole/pass rest with the consultant psychiatrist and should be appropriately recorded in the patient's case file.

Discharge

- Before discharge, the service should ensure the patient's housing conditions are satisfactory and that the patient's family is aware of the patient's pending discharge.

- Following discharge, a discharge summary should be sent to the general practitioner or other components of the psychiatric service responsible for follow-up.
- The discharge summary should set out the principal details of the patient's management and treatment while in hospital including medication on discharge.
- The discharge summary should detail follow-up plans including the role of the general practitioner and give details of diagnosis, treatment and medication in hospital and the results of any tests or investigations carried out.
- Patients on discharge should be supplied with a standard form giving them information on drugs prescribed for them.
- The name of their general practitioner should be supplied to the patient.
- The telephone number of the mental health centre where staff can be contacted and a domiciliary visit or other arrangements made in the case of emergencies should be supplied to the patient.

THE SETTING

Hospital and Unit

- Residential premises should be clean, neat, well maintained and where appropriate provide a variety of day time activities.
- In-patient units should provide:—
 - appropriate levels of safety and security for patients and staff;
 - private bathing facilities;
 - single gender toilet facilities;
 - access to smoking and non-smoking areas;
 - access to private outdoor space;
 - access to public telephone;
 - easy access to public transport, churches and shopping facilities;
 - adequate facilities for the physically disabled;
 - facilities for leisure activities;
 - adequate facilities for visitors;
- All units should be comfortable, maintained in good decorative order and appropriately furnished.
- Grounds adjoining the units and the buildings should be maintained in good condition.
- There should be adequate internal and external signposting.
- All residential in-patient units should be provided with a calendar, clock and wall thermometer.

Catering

- The quality of food for patients should be satisfactory and patients should have reasonable choice.
- There should be a written printed menu reviewed periodically and on display for patients' information.
- The physical environment of dining areas and the quality of tableware should be satisfactory.
- Meals should be provided at socially acceptable times.
- Catering and ancillary staff should be provided with appropriate training.

Maintenance

- There should be easy and ready access to maintenance services which should be supplied promptly and adequately.
- Grounds and gardens should be maintained to a proper standard and sufficient staff should be available to ensure that this is the case.

- All toilet and bathing facilities should be kept clean with the provision of soap, towels and other toilet requisites on a personalised basis individual to each patient.

Privacy and Dignity

- All clothing should be personal to the patient and patients should have adequate storage space for clothing and belongings.
- There should be adequate equipment to wash and dry personal clothing.
- Sleeping accommodation should be adequate in floor area, uncluttered and uncrowded.
- Patients should have rails and curtains for each bed in the multi-bed areas of in-patient units to ensure privacy.
- Visiting times should be prominently displayed and these should be reasonably generous.
- Relatives should have visiting rights outside the normal visiting times where circumstances prevent them from visiting during designated times.
- Patients should never be deprived of appropriate day time clothing with the intention of restricting their freedom of movement unless it is part of a treatment plan determined by a consultant psychiatrist.

Safety Procedures

- The hospital and local units should have a written safety statement.
- There should be a safety committee with an identifiable safety officer.
- Written records of safety committee meetings should be kept.
- Hazard control sheets indicating periodic safety audits and follow-up should be kept in each local area.

Fire Precautions

- Each service should have a fire committee which meets periodically.
- Records of fire committee meetings should be kept.
- Incidents concerning a fire outbreak should be recorded together with action taken by staff in the particular circumstances.
- All staff should have ongoing training courses in fire precaution techniques and evacuation procedures.
- There should be regular checking and inspections of equipment, safety exits and fire escapes.
- Fire orders should be prominently displayed and fire exits clearly marked.
- Residential premises external to the hospital in-patient setting should be provided with a telephone and residents should be aware of telephone numbers to contact in case of emergency.

Out-patient Facilities and Mental Health Centres

- Out-patient clinics, day hospitals and day centres should be suitably located for easy access.
- An appointment system, known to referral agents, ensuring patients have a minimal wait for attendance should be in operation in all community facilities.
- The appointment system should ensure adequate time for consultation with professional staff.
- Mental health centres should form the operational base of mental health teams.
- Mental health centres should allow close co-ordination and integration with primary health care teams.
- Such facilities should include secretarial assistance to ensure letters are issued within the minimum time possible following consultation.
- Adequate documentation in terms of case records and treatment plans should be maintained and safely stored.

Community Residences

- Community residences should be good quality, comfortable, well designed with furnishings and decor to meet the needs of residents.

- Residents should have involvement in choosing or planning changes to furniture and decor in their residence as appropriate.
- There should be a system which monitors the implementation of community residence operational policies and procedures.
- Catering should be efficient with meals varied, well presented and flexibly provided.
- Residents should be encouraged to help with the preparation of food, cooking and cleaning up.
- Patient residential accommodation should not be institutional in appearance.
- There should be reasonable access to public transport and community facilities.
- Residences should be satisfactorily decorated and maintained with adequate security provided to protect property and residents.
- Residences should contain telephones and residents should know who to contact in emergency and contact telephone numbers should be readily available.
- All community residences should be protected by an automatic fire detection system.
- Fire exits should be clearly marked and written fire orders prominently displayed.
- Written records should be kept of fire drills and evacuation exercises.
- Residences should be visited and inspected periodically by the fire prevention officer, health and safety officer, fire equipment service personnel and senior nursing personnel.
- Residents should be encouraged to take charge of their own financial affairs.
- Residents should play an active part in the furnishing and decoration of their homes.
- The weekly scale of charges to residents should be specified and these should be reviewed and revised periodically.
- Arrangements for residents unable to look after their day to day finances should be satisfactory and subject to regular checking.

PERSONAL SAFETY FOR STAFF

Training

- All staff should be trained in the techniques of management of violence and aggression through participation in a recognised training course.
- Training courses relating to management of violence and aggression should be organised on an ongoing basis so all staff have the opportunity to attend refresher courses periodically.
- All staff should be trained in the manual handling of loads and safe lifting techniques.
- If considered appropriate staff should carry personal safety alarms.

GENERAL ADMINISTRATIVE ARRANGEMENTS

Administrative Arrangements

- There should be a document outlining the philosophy and model of care delivery for the service as a whole, and the document should be available in each component of the service and available and understood by every staff member.
- There should be a written local mental health programme adapted to meet the objectives and targets that are enshrined and understood in the philosophy and model of care.
- There should be a written strategy identified and understood by which these targets and objectives may be met.
- There should be mechanisms in place to ensure that through the strategy the programme and its aims are working towards the final targets.
- Mechanisms, such as a service management group, sector groups and so on should be in place to ensure that the strategies, programmes etc. can be applied and realistic targets achieved.

- There should be a clear understanding between service deliverers and policy makers on the budget available so that targets which are feasible and possible, may be achieved.
- At the unit/ward level, day centre/day hospital level or mental health sector headquarters there should be an operational policy which records the agreed information about how that particular component of the organisation operates.
- This policy should be available in written form so that it can be read and understood by all staff members and if necessary by patients and visitors.
- There should be an annual review of the quality, efficiency, and effectiveness of all aspects of the mental health service.
- The review should identify strengths and weaknesses in policy programmes with a view to modifying and improving them.
- These programme goals should be written down and anchored to local objectives.
- A written report of the annual review should be kept.
- Service objectives should be discussed, understood and approved by health board members.
- There should be a good working relationship between health board members, senior executives and service providers.

APPENDIX 3

Procedures for Transfers under Section 208

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.