COMMUNITY PSYCHIATRIC NURSING SERVICE

Report of Review Group
Report of
Review Group on
Community Psychiatric Nursing Service

Introduction

1.1 The Health Services Committee of the Local Government Staff Negotiations Board established a Review Group in November 1982 to review the community psychiatric nursing services. The Review Group held its first meeting on 19 May 1983 and subsequently met on a number of occasions.

1.2

Report of
Review Group on
Community Psychiatric Nursing

To review developments in community psychiatric nursing since the time of the last Study Group Report (1978).

Members of the Review Group

(a) We received a considerable amount of help from people in the health services and indeed outside it. They are too numerous to mention but we wish to thank them for their cooperation and help.

i. Browne, Chief Psychiatrist, EHR.
Mr P. J. Fitzpatrick, Programme Manager, NHB.
(b) We want to record our appreciation to Mr John Dair for his excellent work as Secretary to the Group.
Dr R. Horgan, Consultant Psychiatrist, NWHB.

(c) References in this report to 'he' or 'him' cover both male and female nurses.
Mr G. Murphy, Hospital Administrator, SHB.
Mr. M. Hynes, Chief Nursing Officer, WHB.
Mr O. D'Arcy, Principal Officer, Dept of Health.
Mr. N. P. Walsh, Higher Executive Officer, Dept of Health.
Mr. N. Harrington, Programme Manager, WHB.
Mr J. Dair, Assistant Director of Nursing, EHR, acted as Secretary to the Group.

* Mr. C. O'Malley, SHB, retired from the Health Service on 4/12/83.
** Mr. S. O'Sullivan, WHB, was replaced by Mr. F. O'Shea, WHB, who was appointed Programme Manager, Special Projects Team, in October 1983.
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Report of
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Community Psychiatric Nursing Service

1.

Introduction

1.1 The Health Services Committee of the Local Government Staff Negotiations Board established a Review Group in November 1982 to review the community psychiatric nursing services. The Review Group held its first meeting on 18 May 1983 and subsequently met on ten occasions.

1.2 Terms of reference

To review developments in community psychiatric nursing since the time of the last Study Group Report (1978).

1.3 Members of the Review Group

Mr T Keyes, Programme Manager, EHB (Chairman)
Professor I Browne, Chief Psychiatrist, EHB
Mr P J Fitzpatrick, Programme Manager, MHB.
Mr P Cotter, Chief Nursing Officer, MWHB.
Mr P Black, Chief Nursing Officer, NEHB.
Dr R Horgan, Consultant Psychiatrist, NWHB.
Mr J Cooney, Programme Manager, SEHB.
Mr C Murphy, Hospital Administrator, SHB.*
Mr M Hynes, Chief Nursing Officer, WHB.
Mr D Devitt, Principal Officer, Dept of Health.
Mr P Wylie, Higher Executive Officer, Dept of Health.
Mr S Donoghue, Programme Manager, WHB.**
Mr P McDaid, Programme Manager, WHB.**

Mr J Dair, Assistant Section Officer, EHB, acted as Secretary to the Group.

*Mr C Murphy, SHB, retired from the health service on 1/12/83.
**Mr S Donoghue, WHB, was replaced by Mr P McDaid, WHB, who was appointed Programme Manager, Special Hospital Care, in October 1983.
2. **Background to the Community Psychiatric Nursing Service**

2.1 It is important to look at the development of community psychiatric nursing over the years to appreciate the objectives of the originators of the scheme, to see how it has evolved, and how to structure the scheme to meet current and future needs.

The first recorded community psychiatric nursing service was at Warlingham Park Hospital in Britain in 1954. Community psychiatric nursing in Ireland emerged as a feature of the psychiatric services in the late 1950s and early 1960s and its beginnings can be traced back to the late Dr B Blake, Resident Medical Superintendent, St Dymphna's Hospital, Carlow, and to St Brendan's Hospital, Dublin. Dr Blake felt that it was desirable and possible to maintain psychiatric patients in the community who, prior to that, would have been admitted to hospital as a matter of course.

2.2 The approach was that catchment areas be established and that facilities for direct treatment of patients at community clinics be provided in each such area. In addition, in-patients from each catchment area should, on discharge, be provided with an aftercare service to ensure continuation of correct usage of prescribed drugs, general progress of the patient, and the referral where appropriate of patients needing further medical care.

Initially it was envisaged that aftercare would be provided by psychiatric social workers but, pending the availability of such a grade, Dr Blake advocated the secondment of psychiatric nurses. In 1960 the first such appointment was made and by 1966 the number of nurses had increased to five.

The continuation of clinics and aftercare nursing services made a major impact at St Dymphna's Hospital on the numbers of in-patients which dropped from 533 in 1957 to 325 in 1979.

2.3 The experience was that nurses proved capable and suitable in undertaking a range of community services. It was envisaged that nurses with initiative, leadership and good assessment skills would be able to help to sustain the patient in the community, thereby reducing the need to have recourse to hospital admission. It was also intended that continuity and liaison with public health staff and general practitioners would be enhanced. The service developed on a somewhat uneven pattern throughout the country in the succeeding years and, at the time of the first major review of the service in 1978, the number of community nurses employed had risen to 132.

3. **The 1978 Study Group Report**

3.1 The setting-up of the 1978 Study Group by the Department of Health, with the agreement of the Chief Executive Officers of the health boards, highlighted in a special way the important role of the psychiatric nurse in the future development of the community psychiatric services. The Report of the Study Group made a significant contribution towards formalising the role of the community psychiatric nurse in each health board, particularly in the context of the method of appointment, status, training, and principal duties. The following recommendations from the 1978 Report serve as a backdrop to the present Report: "The care of the mentally ill person requires a degree of specialisation which only the psychiatric nurse is in a position to give. The principle duties of the community nurse will involve participating in the prevention of psychiatric illness, in detecting developing illness and in minimising the effects of psychiatric illness on the family."

3.2 In this context the work of the community psychiatric nurse is seen as complementing the work of other health care professionals in each area. Since it was felt that the number of community psychiatric nurses working in each area would be relatively small the 1978 Study Group did not see the need for a senior grade community psychiatric nurse.
3.3 On the question of the location of the community nurse it was felt that ideally each nurse should live centrally within his/her catchment area. Due to the scattered nature of many rural communities it was realised, however, that this might not always be possible. It was deemed essential that the community nurse should live close to the base of the psychiatric team.

3.4 In dealing with the training aspect of community psychiatric nurses the Study Group rejected the need for a course leading to a special qualification. A short orientation course organised at national level by An Bord Altranais was regarded as being adequate.

3.5 Following the Report of the 1978 Study Group the organisations representing the psychiatric nurses and the management group formulated a series of proposals for a new psychiatric nursing grade. All the parties agreed to recommend acceptance of the proposals (which are set out in Appendix II of the 1978 Report - copy attached).

4. Present position

4.1 This Review Group collected information from all health boards on the present arrangements for delivery of community psychiatric nursing services together with health board proposals for the future development of community psychiatric services, including community psychiatric nursing services.

4.2 Details of the position throughout the country are set out in Appendices III to VII but a selection of relevant information is set out herein.

- No. of community psychiatric nurses employed: 166
- Sex of community psychiatric nurses employed:
  - Male: 101
  - Female: 65
- Present system of recruitment: Competition confined to health board area.
- Rostering arrangements:
  - 5-day week (Monday to Friday): 155
  - Other arrangements: 11
- Average ratio of community psychiatric nurses to population: 1:20,743
  The range is from 1:13,653 to 1:34,245
- Percentage of working week spent on travelling: 23% approximately
- Base from which community psychiatric nurse operates:
  - Psychiatric hospital: 130
  - Community: 36
- Home visits: 49% of workload
- Source of referrals to community service:
  - Hospital: 52%
  - General Practitioners: 22%
  - Other: 26%
- Reporting relationships: Chief nursing officer (usually delegated to assistant chief nursing officer).
The general reporting relationship does not interfere with the usual arrangements in a multi-disciplinary team for clinical responsibility under the supervision of the appropriate consultant psychiatrist.

Nationally there has been an increase of 34 community psychiatric nurses since 1978.

5. **Future organisation of the psychiatric services**

5.1. The Review Group feels strongly that any recommendations on the future of any aspect of the psychiatric services, including the community psychiatric nursing service, must be considered within the context of and with full regard to the likely future shape of the overall psychiatric services.

5.2. The Review Group is aware that a working party under the aegis of the Department of Health is at present preparing a detailed policy document which will incorporate a planning framework for the future development of all the main elements of the service both at hospital and community level. Without wishing in any way to pre-empt the recommendations of the working party, which it is understood will be presenting its report during the coming months, the Review Group feels that there is a broad general consensus at all levels that the psychiatric service of the future will be firmly based on the notion of a comprehensive community service. This overall approach is shared by this Group and was reinforced and reflected to varying degrees in the various submissions which the Study Group received. The common themes emerging envisage and encompass the following general approach:

(a) **Comprehensive service**
   The concept of a comprehensive and integrated psychiatric team serving a defined geographical area or sector.

(b) **Location of team**
   The activities of the area psychiatric team should have as their focal point a centre, or centres, within the area which they serve - rather than that the team should be based exclusively at the mental hospital or other in-patient unit.

(c) **Service to patients**
   Services should be available to patients with the minimum disruption of their normal way of life and as near their own home as possible.

(d) **Continuity of care**
   Continuity of care should be assured through the retention of responsibility by the psychiatric team through all phases of a patient’s treatment.

(e) **Organisation of services**
   If patients are to have easy access to all the services and get maximum benefit from them the services must be organised in a way that will facilitate movement between the different components of the service, so that the psychiatric team responsible for arranging treatment and care for an individual patient will be able to choose the most appropriate elements of service as required, while retaining responsibility for the patient’s treatment.

(f) **Hospital/community relationships**
   The continued development of community services will lead to a diminution of the hitherto dominant role of hospitals.

(g) **Future psychiatric service**
   The comprehensive service will encompass, inter alia, prevention, diagnostic and assessment services, day care centres, day hospitals, short term and long term in-patient care, community based residences, emergency care, family support services,
rehabilitation services. The presence of different elements within the service does not imply a separate independent existence for any of these component parts. The psychiatric service of the future will involve the integration of these many parts into a coherent whole in which the various parts will interrelate and combine to the optimum benefit of patients.

(h) Delivery of the service
The main responsibility for organising and delivering a total range of services within each local sector should rest with a multidisciplinary team, headed by a consultant psychiatrist, in which psychiatric nursing will form a central and integral part. The deployment of adequate numbers of nursing and other personnel should reflect the needs of the sector services.

5.3 Having regard to these main general principles which, it is felt, are likely to determine the future shape and development of the psychiatric service, the Study Group is concerned at what appears to be at present a degree of separateness in certain areas of the country between the hospital-based and the community-based services.

In general, the Review Group accepts that present staffing and other structures, both in nursing and other areas, tend to reflect the dominant position of the hospital in the overall scheme of things, and that this is perhaps understandable given the relative underdevelopment to date of community-based services in many areas of the country. However, if the objective of a total, integrated and community orientated service is to become a reality, the Review Group feels it is essential that any new staffing structures or other organisational arrangements introduced in the future should reflect and facilitate the evolution of the service in this direction. No initiatives should be taken in the short term, however compelling the reasons, which would tend to inhibit and obstruct the attainment of the longer term objectives of the service. This is the main guiding factor which underlies the recommendations in this report.

6. Role of psychiatric nurses

6.1 Psychiatric nurses are generally now required to deliver services under one of the following headings:
(a) Community psychiatric nurses as established following the Study Group Report of 1978.
(b) Supervisory and basic grade nurses working in community based treatment facilities such as day hospitals and day centres. These will be deployed basically on a Monday to Friday week but, as resources develop in the community, there may be a need in some instances for seven-day cover.
(c) Specialist nurses such as counsellors in alcoholism, behaviour, cognative, and psychotherapists.
(d) Hospital based nurses.

6.2 The Review Group envisages that as the psychiatric service evolves along the lines discussed in its Report, i.e. all elements, hospital and extra-mural integrating into a comprehensive service, it will be necessary to train nurses who will operate with equal facility in in-patient, out-patient day care facilities, etc. This, in fact, will require a common basic grade throughout the service.

The present community psychiatric nursing grade which has pioneered the service is ideally placed to assist in the training, support and supervision necessary to implement the foregoing.

6.3 The psychiatric service, as it is now evolving, requires considerable flexibility in the movement of nurses to locations where their expertise may be required from time to time. It is essential that conditions of appointment and duties should reflect this need.
7. **Job description for psychiatric nurses working in the community**

7.1 In the following paragraphs details are given of various aspects of the job description as set down by the 1978 Group together with comments on some aspects of the job description for the purpose of clarification, having regard to the developments in the service since 1978 and further development in the future.

7.2 **Purpose of the job**

To provide care in the community for psychiatric patients who do not require hospital treatment and to help in the rehabilitation of those who have had previous psychiatric in-patient care.

The purpose of the job to 'provide care in the community' is, in many respects, all-embracing without defining 'community'. It has been interpreted to mean care in an area outside the in-patient unit, but we see the in-patient unit as part of the community service.

7.3 **Principal duties and responsibilities**

1. To participate in the prevention of psychiatric illness, in detecting developing illness, and in minimising the effects of psychiatric illness on the family.

1.1 Participating in preventive psychiatry by attempting to ensure early detection of psychiatric illness.

1.2 Visiting in their homes, at the request of the family doctor or senior psychiatrist, patients who have displayed psychiatric symptoms and assisting in possible courses of action in relation to their care and treatment in the community.

1.3 Arranging, whenever necessary, for early referral of patients to and treatment by the appropriate services.

1.4 Participating in health education activities.'

The details received from health boards show that 49% of time is spent on home visits. This contrasts sharply with an average of 2½% of time spent in day facilities. This is largely due to the absence of day facilities.

It is noted that in the Dublin area, where there has been somewhat more progress in providing community facilities, the time element spent in day centres represents 11% but it must be recorded that in the Dublin area the day facilities available are still much below what is required.

The psychiatric nurse working in the community should be encouraged to make the best use of his time by encouraging patients to attend the local centres for treatment rather than always visiting them individually at home. We believe that the psychiatric nurse working in the community should work for some part of the day in the local treatment centres etc, relating to the supervisor there in the same way as the other professionals. Individual visitation must continue, but there are opportunities for greater utilisation of the primary care teams in continuing care. Patients would benefit through coming to treatment centres and this in itself would contribute to their rehabilitation.

7.4 2. To provide psychiatric nursing care of a physical and psychological nature under the general direction of the appropriate senior* psychiatrist and in conjunction with the family doctor for patients in need of such care in the community.

2.1 Providing supportive care for psychiatric patients in the community including the supervision and, where necessary, administration of drugs under medical direction.

2.2 Participating in crisis intervention as required.

2.3 Building up a therapeutic relationship by regular visitation and encouraging patients to enjoy social activities, e.g. shopping and meeting people.

*now consultant psychiatrist.
2.4 Encouraging patients to avail of recommended services, e.g. day care facilities, hostels, occupational and industrial therapy, sheltered workshops, therapeutic clubs and follow-up clinics as necessary.

2.5 Participating as required in the operation of community based services as listed at 2.4 above.

With regard to paragraph 2.3 above, the views of the Group are reflected in the comments in paragraph 1.

The elements of the service mentioned in paragraph 2.4 will play an increasing role as the core treatment setting in the future. It is likely that a psychiatric nurse working in the community would, as a member of the multidisciplinary team, be based at one of these units. Patients would be referred there for assessment and treatment, and the unit would be identified as a treatment setting rather than solely an aftercare arrangement following treatment in hospital. This change in location would make these elements of the service central to the work of the psychiatric nurse working in the community. The implementation of this approach will only be feasible when the necessary community resources are provided.

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3. To work in close liaison with the other workers in the field of health and welfare.

3.1 Participating in multidisciplinary assessment of patients.

3.2 Liaising with other members of the community health team and, in particular, with general practitioners and public health nursing staff.

3.3 Becoming familiar, where required, with patients before their discharge from hospital, and facilitating their discharge.

3.4 Monitoring patients’ progress and referring them to the appropriate doctors as required.

3.5 Arranging for mobilisation of community resources and help as required.

3.6 Advising public health nurses and other community care personnel, whenever they so request, in relation to psychiatric patients who come to their attention.

3.7 Liaising with, advising and participating in rehabilitation services in relation to the management and care of psychiatric patients referred to them and encouraging in every way possible the integration of these patients into the community.

The 1978 Report emphasises the importance of the community psychiatric nurse and the public health nurse having a close working relationship. We wish to underline this provision and, indeed, it may be necessary for the psychiatric nurse working in the community to have formal liaison with the public health nurse. This liaison might be best achieved by an arrangement whereby the psychiatric nurse working in the community might attend meetings of the local community care team. The Committee believes that there are greater opportunities for involving primary care staff in the continuing care of patients, for instance, the Committee believe that the giving of depot injections by community psychiatric nurses should be the exception rather than the rule.

4. To provide support and advice for the family of the patient.

4.1 Advising relatives on the management and care of psychiatric patients and developing a greater understanding and acceptance of the patients by their relatives.

The provision of community facilities will strengthen the support of the families of the mentally ill. We also received representations about identity of community psychiatric nurses and we recommend that an identity system be implemented where this has not already been done.

5. To assist as required with on-the-job training of student nurses and post-graduate trainees, who require experience in community psychiatric nursing.

5.1 Allowing student nurses and post-graduate trainees to accompany him/her in the performance of his/her community psychiatric nursing duties.
Difficulties have arisen in some areas in relation to community psychiatric nurses transporting students in their cars for the purposes of this duty. It is understood that this difficulty is related to car insurance. It is recommended that this problem be given urgent attention so that it may be resolved without delay. It is an essential part of any profession that it takes responsibility for training future entrants in all aspects of work.

7.8 To make such reports and keep such records as are required from time to time.

6. Reporting to the relevant consultant on visits to patients indicating progress and any findings which would require direction or attention.

6.2 Keeping such records on each patient as are considered necessary by the medical staff or the chief nursing officer/unit nursing officer.

6.3 Keeping such other records and making such other reports as may from time to time be requested.

It is important that all psychiatric nurses working in the community have adequate information on each patient they are dealing with and the consultant psychiatrist should satisfy himself that an adequate system is in operation to verify the accuracy on such matters as identification and medication. This is particularly important where a locum has to be employed. Consideration should be given to devising a standard system to meet this problem.

The requirement to report to the relevant consultant on visits to patients has come to be interpreted as referring mainly to home visits. It should more accurately be taken to mean reporting on any nursing intervention with or on behalf of patients.

7.9 To discharge such other duties applicable to the office as may be assigned to him/her from time to time.

This is an important provision in view of the evolving nature of the psychiatric service.

8. Training

8.1 Position to date

The 1978 Report considered that a course of training leading to a special qualification in community psychiatric nursing was not necessary. It was recognised that some instruction aimed at introducing the nurse to community work was desirable and a short orientation course was recommended with emphasis on such matters as interviewing techniques, social legislation and other relevant matters. Bord Altranais accepted responsibility for running the course.

8.2 A total of 111 community nurses completed An Bord Altranais course. A further 14 completed a comprehensive course organised by the North Western Health Board, 8 community nurses had other formal training. A total of 65 community nurses had informal training over a wide range of subjects.

8.3 Student nurses

The present syllabus of training, which came into operation in 1968, covers various aspects of the care and treatment of the patient. Since 1968 An Bord Altranais have required student nurses to have six weeks' community experience and to attend eight out-patient clinic sessions. While An Bord Altranais have had this requirement, it must be said that some training schools were less than diligent in meeting this requirement. Nevertheless, a substantial number of psychiatric nurses have had community experience as part of their training.
8.4 With the continued decline in hospital in-patient numbers and the build-up of a comprehensive and integrated local psychiatric service outside the hospital setting, the curriculum of training for psychiatric nursing must reflect this shift in emphasis.

8.5 Orientation course for psychiatric nurses working in the community.

Notwithstanding the fact that many nurses have had community experience during their training, it is recommended that an orientation course for those undertaking full time community nursing should continue to be held. Because of the numbers involved we recommend that the course be organised on a national basis.

8.6 Continued education

While a course of training leading to a special qualification in community psychiatric nursing is not considered to be warranted, there is an absolute need for continuing post-graduate training for all nurses. In acute psychiatry there are different elements within the service which interrelate with each other. The psychiatric nurses involved in any area of acute psychiatry do not function as separate independent elements but are also inter-related. Continued training should reflect this. Such training should be undertaken as near as possible to the team base.

8.7 Method of training

On the assumption that all psychiatric nurses have a uniform basic knowledge of psychiatric disorders and therapies, it would be easy to list headings for in-service training which would probably include such topics as counselling, communications and social legislation, but these would not take cognisance of the various levels of training and experience of course participants. A change from didactic lectures to experiential learning is recommended. Course objectives should be set. The Group places particular emphasis on the development of the following skills:

1. Skills in assessing the needs of the mentally ill and their families.
2. Skills in developing therapeutic relationships with patients and their families.
3. Skills in providing nursing care, treatment and rehabilitation to meet the needs of individual patients.
4. Ability to give appropriate information and guidance to the patient and his family, if necessary by teaching appropriate skills and principles of therapy.
5. Skills in the management of case loads and in organising priorities.
6. Ability to work effectively in a multidisciplinary team.
7. Ability to recognise personal limitations, and when to seek guidance and assistance from other members of the team.

The objective should be that all nurse training will be community orientated and, until such time as that is achieved, it is recommended that existing orientation courses be expanded.

It is the responsibility of the chief nursing officer in consultation with the consultant leading the team and the appropriate nurse manager to organise in-service training for the nurse members of the team as part of the overall training programme.

9. Experience and recruitment

9.1 The Review Group is satisfied that certain elements of community based services such as day hospitals and day centres will be developed to a much greater extent in the future and that the more traditional hospital based elements will decline. There will be a need, therefore, for nurses who have worked largely in a hospital based setting to gain experience of other community facilities.
9.2 The 1978 Study Group recommended recruitment on a national basis. This was subsequently changed to a health board basis following negotiation. This Group is also of the view that all posts of psychiatric nurse should be open without restriction.

10. **Promotion and supervision**

10.1 The 1978 Study Group did not recommend that a senior grade of community psychiatric nurse should be introduced because -
(a) the numbers working in any area are small;
(b) such an arrangement could interfere with the reporting relationships and clinical responsibilities to which reference has already been made.

10.2 These reasons are still valid. We have described the way in which we believe the service is developing and will continue to develop. This, in our view, requires an integrated and unified nursing structure. The provision of a supervisory nurse in community psychiatric nursing would be contrary to the normal reporting relationships in such a structure and, accordingly, the provision of such a post is not recommended.

10.3 The Group considers, however, that at the more general supervisory level more formal arrangements are necessary. Pending the establishment of the sector teams referred to, it is recommended that at least one assistant chief nursing officer be allocated to community services in each area. Part of the duties should be to co-ordinate, monitor and evaluate the psychiatric nursing service in the community. It is considered that existing community psychiatric nurses in general would be suitable candidates for the post of assistant chief nursing officer. The present requirement in regard to supervisory experience of staff appears to be a barrier to the existing community psychiatric nurse competing successfully for assistant chief nursing officer grades, although some have been promoted to these posts. It is recommended that the conditions of office for the post of assistant chief nursing officer should be reviewed to remove what is regarded by the existing community psychiatric nurse as an obstacle to their promotion within the psychiatric service generally. Our entire Report places emphasis on the community aspects of psychiatry and it is important that this be reflected at senior nursing level.

11. **Rostering**

11.1 Community psychiatric nurses generally work Monday to Friday, although some who were appointed after the 1978 Report and had been doing such work prior to the Report were allowed to retain on a personal basis the roster they had been working; this generally meant that every second Sunday was worked. An arrangement was also made whereby community psychiatric nurses called out for emergencies after hours are paid overtime.

11.2 The group has received submissions that community psychiatric nurses should be available for duty at weekends. The demands for emergency call outs following the 1978 Report have been examined. The number of such calls have been few. It is possible that such calls were compensated for on a time-off basis or, indeed, it is possible that emergencies were covered by community psychiatric nurses who were entitled to work every second Sunday. The cost of rostering community psychiatric nurses in the community for weekend duty, even on a limited scale, would be considerable and, on the basis of available information, the Group does not consider that it would be justified. It is recommended that the existing system be continued and monitored.

11.3 The Group considers that as community services grow, cover for weekends will be needed, but it is not clear how, if this happens, such cover should be provided. It is recommended that the assistant chief nursing officer responsible for the overall supervision of psychiatric nurses working in the community should assess in consultation with the area team the need for nursing services outside of normal working hours. In the meantime, the system outside normal working hours should continue on the basis recommended in the 1978 Report.
12. Monitoring and evaluation

12.1 Little monitoring of the community psychiatric nursing service has been done. What monitoring is done concentrates on time and motion rather than effectiveness. Present monitoring is concerned with ensuring that nurses:

1. Work the allotted time.
2. Submit accurate records of mileage travelled and time spent away from headquarters.
3. Give details of the number of patients visited.
4. Attend the designated out-patient clinic.
5. Receive their allotted annual leave and other entitlements.
6. Submit reports on individual patients as requested.

All areas monitor some or all of the above.

12.2 What is not monitored is:

(a) The need for intervention in each case.
(b) The contribution the nurse makes to the treatment of patients and the prevention of re-admission.
(c) The extent to which the nurse supports the family of the patient.
(d) The extent of liaison with relevant agencies.
(e) When it is appropriate to refer to another health agency.
(f) When it is appropriate to discontinue visits to an individual patient.
(g) The order of priorities of community nurses.
(h) The effectiveness of the intervention in each case, in terms of outcome.

It is vital that these areas be monitored and evaluated. Each health board should be encouraged to set up at least one pilot scheme and the results should be published. The lessons to be learned from such an exercise will be invaluable in correctly structuring the growing community-based service.

CONCLUSION

The community psychiatric nurses now in office have functioned very well in the community on the existing basis and, indeed, their flexibility and expertise have encouraged other professionals to develop in the community. These people have pioneered much of the community development and the fact that there is a general acceptance of this owes much to their efforts.

We have consulted extensively with the different interests throughout the services and it is quite clear that the needs of the service now evolving demand and require a unified nursing structure. Our recommendations are aimed at achieving that objective, this is what we believe is in the best interests of the service as a whole. We believe that all nursing is part of the unified nursing structure and should get the same training and experience and should be expected to respond to the changing needs of patients.

The Review Group was confronted with some difficulties as it was reviewing community psychiatric nursing.

(a) Consideration of the community psychiatric nursing concept in isolation from the totality of the psychiatric nursing service.
(b) Absence of the detailed policy document on psychiatry being prepared by a working party under the aegis of the Department of Health.
(c) Results of review by An Bord Altranais in pre-registration training for psychiatric nursing not yet available.
(d) Consideration in another forum of changes in the conditions of employment for psychiatric nurses, necessitated by changes in the equality legislation.

Nevertheless, we are satisfied that this Report, viewed either in isolation from, or in the context of what emerges from, any or all of the above, represents the correct path which psychiatric nurses working in the community must follow.
10. Promotion and supervision

10.1 The 1978 Study Group did not recommend that a separate category of psychiatric nurse be created.

10.2 The reasons are still valid. We have described the way in which we believe the service is developing and will continue to develop. This, in our view,

10.3 The Group considers that as community services grow, so far for the category of psychiatric nurse be created.

10.4 The reasons are still valid. We have described the way in which we believe the service is developing and will continue to develop. This, in our view,
APPENDIX I

Job description for community psychiatric nurses as set out by the 1978 Study Group.

Purpose of job
To provide care in the community for psychiatric patients who do not require hospital treatment and to help in the rehabilitation of those who have had previous in-patient care.

Principal duties and responsibilities

1. To participate in the prevention of psychiatric illness, in detecting developing illness, and in minimising the effects of psychiatric illness on the family.
   1.1 Participating in preventive psychiatry by attempting to ensure early detection of psychiatric illness.
   1.2 Visiting in their homes, at the request of the family doctor or senior psychiatrist, patients who have displayed psychiatric symptoms and assisting in possible courses of action in relation to their care and treatment in the community.
   1.3 Arranging whenever necessary for early referral of patients to and treatment by the appropriate services.
   1.4 Participating in health education activities.

2. To provide psychiatric nursing care of a physical and psychological nature, under the general direction of the appropriate senior psychiatrist and in conjunction with the family doctor, for patients in need of such care in the community.
   2.1 Providing supportive care for psychiatric patients in the community including the supervision and, where necessary, administration of drugs under medical direction.
   2.2 Participating in crisis intervention as required.
   2.3 Building up a therapeutic relationship by regular visitation and encouraging patients to enjoy social activities, e.g. shopping and meeting people.
   2.4 Encouraging patients to avail of recommended services, e.g. day care facilities, hostels, occupational and industrial therapy, sheltered workshops, therapeutic clubs and follow-up clinics, as necessary.
   2.5 Participating as required in the operation of community based services as listed at 2.4 above.

3. To work in close liaison with the other workers in the field of health and welfare.
   3.1 Participating in multidisciplinary assessment of patients.
   3.2 Liaising with other members of the community health team and, in particular, with general practitioners and public health nursing staff.
   3.3 Becoming familiar, where required, with patients before their discharge from hospital and facilitating their discharge.
   3.4 Monitoring patients' progress and referring them to the appropriate doctors as required.
   3.5 Arranging for mobilisation of community resources and help, as required.
   3.6 Advising public health nurses and other community care personnel, whenever they so request, in relation to psychiatric patients who come to their attention.
   3.7 Liaising with, advising, and participating in rehabilitation services, in relation to the management and care of psychiatric patients referred to them and encouraging in every way possible the integration of these patients into the community.
4. To provide support and advice for the family of the patient.

4.1 Advising relatives on the management and care of psychiatric patients and in developing a greater understanding and acceptance of the patients by their relatives.

5. To assist as required with on-the-job training of student nurses and post-graduate trainees who require experience in community psychiatric nursing.

5.1 Allowing student nurses and post-graduate trainees to accompany him/her in the performance of his/her community psychiatric nursing duties.

6. To make such reports and keep such records as are required from time to time.

6.1 Reporting to the relevant consultant on visits to patients indicating progress and any findings which would require direction or attention.

6.2 Keeping such records on each patient as are considered necessary by the medical staff or the chief nursing officer/unit nursing officer.

6.3 Keeping such other records and making such other reports as may from time to time be requested.

7. To discharge such other duties applicable to the office as may be assigned to him/her from time to time.
APPENDIX II

Proposals for the grade of community psychiatric nurse formulated after issue of the 1978 Study Group Report.

Proposed grade of community psychiatric nurse

Background

1.1 Consequent on claims submitted by the organisations representing psychiatric nurses and the subsequent preparation of a management study group report on the community psychiatric nursing services, a series of proposals have been formulated regarding the introduction of a new psychiatric nursing grade with the designated title of community psychiatric nurse.

1.2 The parties to the discussions were the Local Government Staff Negotiations Board, representing the eight health boards, and the Irish Transport and General Workers' Union, the Workers' Union of Ireland and Psychiatric Nurses' Association.

1.3 All of the parties to the discussions have agreed to recommend acceptance of the proposals.

The grade

2.1 The role, function and deployment of community psychiatric nurses would be as proposed in the Study Group Report.

Recruitment

3.1 Psychiatric nurses already working in the community and who have completed twelve months' continuous whole time service in the community would be offered appointment without competition.

3.2 In situations where psychiatric nurses have not been assigned to working in the community on a continuous whole time basis, but where the practice exists whereby psychiatric nurses are rotated through the community service, the appropriate number of whole time community psychiatric nursing posts will be filled on a once-off basis through competition confined to the staff of the hospital concerned or, in cases where community services are provided by a limited group of designated nurses, by competition amongst those designated nurses.

3.3 Community RPNs will be recruited through competition confined within the health board area to permanent, qualified psychiatric nurses who are practising their profession in a public psychiatric hospital, public psychiatric units, the community psychiatric service, or in voluntary agencies providing psychiatric services to public patients.

This provision will apply equally in the public and voluntary agencies concerned.

The employer will clearly state the catchment area of each vacancy advertised.

This clause will be reviewed within two years from the date of agreement.

Training

4.1 Training will be as recommended in the Study Group Report.

Remuneration

5.1 Salary scale: It is proposed that the following salary scale would apply to the grade of community nurse, with effect from 1 April 1979.

£4,457; £4,540; £4,621; £4,707; £4,789; £4,871; £4,968; £5,064 pa.

5.2 An allowance of £212 pa would be payable to compensate for contingencies arising from the nature of the service provided, which management and unions accept involves a measure of social inconvenience because of demands made outside of the normal working week.
Overtime
5.3 In exceptional cases whereby community psychiatric nurses are rostered for duty at weekends, standard overtime rates would apply. The allowance referred to at 5.2 would meet all other contingencies.

Assimilation
5.4 Assimilation to the new scale would be on the basis of continuous years' service in the community. However, in assimilation, due regard would be had to pre-assimilation remuneration in instances where there was an overlap of scales and where assimilation on the basis of circular 10/71 would be more favourable than assimilation on the basis of service.

Working week
5.5 The normal working week would be Monday to Friday. In a limited number of cases where the current working week is different, nurses assigned to the community on a continuous basis and who have traditionally worked such rosters would be permitted to continue working such rosters on a personal basis only. The normal working week for all future entrants would be Monday to Friday.

Annual leave
5.6 The annual leave entitlement for the grade of community nurse would be 31 calendar days.

Public holidays
5.5 Community nurses would not normally be rostered to work on public holidays. However, in situations where they would be rostered to work on a public holiday the normal compensatory provisions would apply.

Payment on assimilation
5.8 As part of assimilation in the new grade as defined in the Study Group Report, it is proposed to make a payment of £500 to each community psychiatric nurse with not less than one year's continuous service in the community as at 1 April 1979. Pro rata payments would be made in respect of nurses appointed with less than one year's continuous service.
## APPENDIX III

<table>
<thead>
<tr>
<th>HEALTH BOARD</th>
<th>No. of CPNs</th>
<th>Method of Promotion</th>
<th>Qualifications</th>
<th>Nos. with Formal Training</th>
<th>Average Mileage</th>
<th>Service Integrated</th>
<th>Base</th>
<th>Ratio of Population</th>
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</thead>
<tbody>
<tr>
<td>E H B</td>
<td>54</td>
<td>Automatic 14</td>
<td>Internal 25</td>
<td>External 15</td>
<td>RPN 42</td>
<td>RPN/SRN 12</td>
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<td>RPN/SRN 10</td>
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<td>Internal 20</td>
<td>External 1</td>
<td>RPN 39</td>
<td>RPN/SRN 4</td>
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<td>Internal 9</td>
<td>External 3</td>
<td>RPN 17</td>
<td>RPN/SRN 3</td>
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</tr>
<tr>
<td>MHB</td>
<td>10</td>
<td>Automatic 10</td>
<td>Internal 10</td>
<td>External 1</td>
<td>RPN 42</td>
<td>RPN/SRN 8</td>
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<td>Internal 17</td>
<td>External 4</td>
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<td>Internal 14</td>
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<td>RPN/SRN 8</td>
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<td>Automatic 1</td>
<td>Internal 8</td>
<td>External 1</td>
<td>RPN 42</td>
<td>RPN/SRN 8</td>
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<td></td>
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<tr>
<td>TOTAL</td>
<td>166</td>
<td></td>
<td></td>
<td></td>
<td>133</td>
<td>33</td>
<td>128</td>
<td>314 average per</td>
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<td></td>
<td>1 : 20,743</td>
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</tr>
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<td></td>
</tr>
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**Note:** The table above represents the sales and profit data for the years 1990 to 1997.
### APPENDIX IV - Age Structure of CPNs

<table>
<thead>
<tr>
<th>Health Board Area</th>
<th>Under 25 years</th>
<th>25 - 30 years</th>
<th>30 - 40 years</th>
<th>40 - 50 years</th>
<th>50 - 65 years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>E H B</td>
<td></td>
<td>11</td>
<td>17</td>
<td>19</td>
<td>7</td>
<td>54</td>
</tr>
<tr>
<td>S E H B</td>
<td></td>
<td>2</td>
<td>10</td>
<td>10</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>S H B</td>
<td></td>
<td>2</td>
<td>8</td>
<td>8</td>
<td>4</td>
<td>22</td>
</tr>
<tr>
<td>M W H B</td>
<td></td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>M H B</td>
<td></td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>W H B</td>
<td></td>
<td>5</td>
<td>10</td>
<td>8</td>
<td>2</td>
<td>25</td>
</tr>
<tr>
<td>N W H B</td>
<td></td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>N E H B</td>
<td></td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>24</strong></td>
<td><strong>52</strong></td>
<td><strong>59</strong></td>
<td><strong>31</strong></td>
<td><strong>166</strong></td>
</tr>
</tbody>
</table>
## APPENDIX V - Existing Arrangements for Weekend etc. Cover

<table>
<thead>
<tr>
<th>Health Board</th>
<th>Weekends</th>
<th>Nights</th>
<th>Public Holidays</th>
<th>Emergency</th>
<th>Method of Compensation</th>
</tr>
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<tbody>
<tr>
<td>E H B</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>1 or 2 CPNs by arrangement</td>
<td>Time off</td>
</tr>
<tr>
<td>S E H B</td>
<td>1 CPN on call 1 Sat 1 CPN on duty) only Rostered over 7 days in one hospital</td>
<td>Nil</td>
<td>Nil</td>
<td>As required</td>
<td>Time off and Saturday premium</td>
</tr>
<tr>
<td>S H B</td>
<td>1 CPN on duty in Cork</td>
<td></td>
<td>1 CPN on duty</td>
<td>CPN may be called</td>
<td>Time off</td>
</tr>
<tr>
<td>M W H B</td>
<td>1 Hospital - rostered</td>
<td>As required</td>
<td>Rostered</td>
<td>As required</td>
<td>Time off and premium</td>
</tr>
<tr>
<td>M H B</td>
<td>Available for emergencies</td>
<td>Available for emergencies</td>
<td>Normal working</td>
<td>As required</td>
<td>Time off Premium for public holiday</td>
</tr>
<tr>
<td>W H B</td>
<td>Available if called by Consultant</td>
<td>Available if called by Consultant</td>
<td>Normal working</td>
<td>Available if called</td>
<td>Overtime and time off</td>
</tr>
<tr>
<td>N W H B</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>CRN may be called</td>
<td>Time off</td>
</tr>
<tr>
<td>N E H B</td>
<td>Available for emergencies</td>
<td>Available for emergencies</td>
<td>2 CPNs on hospital duty others as required</td>
<td>As required</td>
<td>Time off</td>
</tr>
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</table>
APPENDIX VI - Caseload of each CPN, % of time

<table>
<thead>
<tr>
<th>HEALTH BOARD</th>
<th>Prevention</th>
<th>Hospital</th>
<th>Home Visits</th>
<th>OPD</th>
<th>Day Hosp.</th>
<th>Day Centre</th>
<th>Consultation with other professionals</th>
<th>Alcoholics</th>
<th>Drugs</th>
<th>Other</th>
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<tbody>
<tr>
<td>E H B</td>
<td>15%</td>
<td>9%</td>
<td>35%</td>
<td>15%</td>
<td>5%</td>
<td>6%</td>
<td>10%</td>
<td>3%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>S E H B</td>
<td>5%</td>
<td>20%</td>
<td>48%</td>
<td>10%</td>
<td>-</td>
<td>-</td>
<td>5%</td>
<td>2%</td>
<td>-</td>
<td>10%</td>
</tr>
<tr>
<td>S H B</td>
<td>5%</td>
<td>20%</td>
<td>40%</td>
<td>5%</td>
<td>1%</td>
<td>5%</td>
<td>14%</td>
<td>5%</td>
<td>1%</td>
<td>4%</td>
</tr>
<tr>
<td>M W H B</td>
<td>Included under Home Visits</td>
<td>25%</td>
<td>60%</td>
<td>5%</td>
<td>-</td>
<td>-</td>
<td>5%</td>
<td>5%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>M H B</td>
<td>14%</td>
<td>17%</td>
<td>48%</td>
<td>14%</td>
<td>-</td>
<td>1%</td>
<td>3%</td>
<td>2%</td>
<td>1%</td>
<td>-</td>
</tr>
<tr>
<td>W H B (approx.)</td>
<td>10%</td>
<td>12%</td>
<td>55%</td>
<td>10%</td>
<td>-</td>
<td>-</td>
<td>10%</td>
<td>2%</td>
<td>1%</td>
<td>-</td>
</tr>
<tr>
<td>N W H B</td>
<td>10%</td>
<td>5%</td>
<td>55%</td>
<td>2%</td>
<td>-</td>
<td>2%</td>
<td>10%</td>
<td>10%</td>
<td>1%</td>
<td>5%</td>
</tr>
<tr>
<td>N E H B</td>
<td>4%</td>
<td>19%</td>
<td>50%</td>
<td>12%</td>
<td>-</td>
<td>-</td>
<td>5%</td>
<td>4%</td>
<td>-</td>
<td>6%</td>
</tr>
<tr>
<td><strong>Total Average</strong></td>
<td><strong>7.87%</strong></td>
<td><strong>15.87%</strong></td>
<td><strong>48.87%</strong></td>
<td><strong>9.12%</strong></td>
<td><strong>.75%</strong></td>
<td><strong>1.75%</strong></td>
<td><strong>7.75%</strong></td>
<td><strong>4.12%</strong></td>
<td><strong>0.62%</strong></td>
<td><strong>3.25%</strong></td>
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</table>
APPENDIX VII

Other Psychiatric Nurses working in the community

<table>
<thead>
<tr>
<th>HEALTH BOARD</th>
<th>Day Hospitals</th>
<th>Day Centres</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>EHB</td>
<td>13</td>
<td>22</td>
<td>6</td>
</tr>
<tr>
<td>SEHB</td>
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<td>1</td>
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<tr>
<td>NEHB</td>
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<tr>
<td>TOTAL</td>
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<td>12</td>
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