Mental Health Commission
Coimisiún Meabhair-Shláinte

ANNUAL REPORT | TUARASCÁIL BHLIANTÚIL

including the Report of the Inspector
of Mental Health Services 2005

2005

Book Two (of Six)

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Health Service Executive
Cavan/Monaghan, Louth/Meath

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CAVAN GENERAL HOSPITAL

DEPARTMENT OF PSYCHIATRY, ACUTE UNIT

Date of inspection: *20th July 2005*

Number of beds: *20 integrated*

DESCRIPTION

The acute unit is a single-storey ward in the lower ground floor of Cavan General Hospital. There were 12 patients on the unit on the day of inspection, five on Temporary status and seven on Voluntary status. The unit provides acute care but a large percentage of patients are elderly and have high physical dependency levels. Four consultant-led teams admit to this unit. The door to the unit was locked on the day of inspection.

REFERRAL

Referrals come from the home-based treatment teams of the general adult service in Cavan, the assertive outreach team of the rehabilitation mental health team in Cavan and the service for later life, which serves both Cavan and Monaghan. Some referrals come from the A&E or from outpatient clinics.

PROCESS OF ADMISSION

No children under 16 years are admitted to the unit. People with moderate intellectual disability are occasionally admitted. Decisions to admit to the unit are made by the consultant psychiatrist or the NCHD in consultation with the consultant psychiatrist. The initial treatment plan is documented in the clinical file and the new patient is reviewed by the consultant within 24 hours.

CARE PLAN

The care plan is documented in the clinical file. Weekly multidisciplinary team meetings are held and a nurse from the unit attends. Family meetings occur on the unit, especially prior to discharge. Discharge planning is informal but begins as soon as possible and the relevant community teams are involved in this.

NURSING PROCESS

The Orem nursing model is in use and a key nurse is in place. There are two levels of observation: general and special. Staff wear uniforms and name badges, which double as access keys to the unit.

ACCESS TO THERAPY

The consultant psychiatrists visit the ward a number of times each week. Other members of the multidisciplinary team are based in the hospital and can be accessed easily. Referrals for medical and surgical consultations are referred upstairs and a quick response is usually forthcoming. Staff can access laboratory results quickly.

ACCESS TO THERAPEUTIC PROGRAMMES

There is very little by way of therapeutic activity on the unit. Nursing staff provide relaxation tapes and try to engage patients in games and walks. There is no occupational therapist employed on the unit and space for therapeutic activities is extremely limited. Some patients attend the day hospital prior to discharge.

ECT

There is an ECT policy in place. Written consent is obtained from the patient, who is provided with written information. The dedicated ECT suite has one treatment bed and two recovery beds. There is no dedicated ECT nurse or consultant psychiatrist. Preparation occurs on the unit, from where the patient goes to a waiting area. ECT consent forms and register are in order.

SECLUSION

There is no seclusion carried out on the unit and there is no seclusion room.

CLINICAL RISK MANAGEMENT

A policy on risk management is available. Alarms are in place in the various offices and two personal attack alarms are used by nursing staff. These are not pinpoint alarms and rely on the noise produced to evoke a response from other staff. There are policies on alcohol and illegal drugs, giving medication without consent, patients going missing, and the management of violent episodes. The personal belongings of patients are searched at the time of admission and at other times if clinically indicated and with the patient's consent. Serious incidents are recorded and this data is collected for action and for audit purposes. Cot sides and safety belts are sometimes used but not always with the authorisation of the consultant psychiatrist.

UNIT MANAGEMENT

Elderly patients are occasionally transferred to Ward 8 in St. Davnet's Hospital on a temporary basis due to overcrowding or pressure on staff. Long-term transfers to Ward 8 also occur. There is currently one patient awaiting appropriate discharge placement. The door to the unit is usually locked in order to prevent some of the patients from wandering. Several patients are allowed to leave the ward unaccompanied with the permission of the consultant psychiatrist. This is a self-staffing unit. The staff complement is three or four nurses by day and two or three nurses at night. There is usually one ward attendant on duty from 0800h to 1700h and the cleaning of the unit is done by general hospital staff.

There is no ward clerk although the medical secretaries are based on the lower ground floor. The main hospital reception switchboard puts calls through to the ward and ward staff have to respond to callers to the door of the unit. Phlebotomy services are provided by the general hospital staff. Newspapers, TV and radio are provided. There is no CCTV and the ward is not used for other purposes. The maintenance service to the unit is good. Visiting times are from 1400h to 2030h. Drinks and snacks are provided at set times during the day. Meal times are 0815h, 1230h and 1700h. Patients are served their meals at the table and make their choice of food on the previous day.

SERVICE USER INVOLVEMENT

There are relevant information leaflets available. Information is posted about the complaints policy and patients' rights. No community meeting is held on the unit nor is there any formal way of seeking the opinions of patients or carers about the service. There is no advocacy service to the patients of this unit.

ENVIRONMENT

The unit was clean and bright and was painted recently, but it felt cramped and there was a shortage of space for therapeutic activities and offices. The corridors were wide and the unit was accessible for patients with physical disabilities. There was a lift to the main hospital corridor. The unit was locked with a card entry system. The unit did not have open access to outside areas except for a small, enclosed courtyard, which was overlooked by the main hospital. There were three 6-bed rooms and two single rooms. The compact nature of the unit meant that it was occasionally noisy at night. There was no quiet area on the unit. There was an open plan lounge and dining area. The majority of patients slept in a large dormitory area. There was no visitors' room and the only interview room, which was located off the main unit, was large and not well furnished. The clinical room had cardio-pulmonary resuscitation equipment, oxygen, suction, phlebotomy and dressing materials but no examination couch. The medication storage area was appropriate. The admissions area also functioned as a waiting area for outpatient appointments. It was some distance from the unit but had adequate seating and plenty of information leaflets.

RECORDS

During the past year, staff experimented with a system of integrated clinical files. They have now reverted to separate nursing and medical files for operational reasons. The front cover of the main clinical files contained name, address, date of birth, hospital number and GP's name. Inside the cover was a patient admission sheet. The patients' charts were tidy and manageable. Entries were all dated and signed but not all signatures were legible, nor was

the person's title always used. The charts contained treatment plans, progress reports and consultant reviews but no entries from social workers, occupational therapists or psychologists. There were frequent entries from NCHDs and consultant psychiatrists.

The nursing notes were signed, dated and legible but full names and titles were not always used. They contained entry sheets, assessment sheets and a nursing history, assessment form and care plan but these were not always completed. The team for Psychiatry of Later Life (POLL) use detailed assessment forms that when completed provide a detailed multidimensional overview of the patient's history and present condition. The medication prescription and administration sheets are kept in ring binder folders, which are untidy and had many loose sheets. The prescription and administration sheets were signed and dated but some of the signatures were not easily identifiable. The generic names of drugs were used. The discontinuation of medication was not always signed and dated.

STAFF TRAINING

A training programme is in place for nursing staff. Staff have received training in control and restraint techniques, breakaway techniques and cardio-pulmonary resuscitation. Information on medication is provided by pharmaceutical representatives.

ST DAVNET'S HOSPITAL, MONAGHAN

WARD 4

Date of inspection: *21st July 2005*

Number of beds: *20 beds*

DESCRIPTION

This unit is described as a 20-bed psychogeriatric ward for female patients. The ward has an open door policy. On the day of inspection, there was one patient on Temporary status and four on Person of Unsound Mind (PUM) status.

REFERRAL

The main source of referral is the team for Psychiatry of Later Life (POLL). The community rehabilitation team also have access to the unit. The process of referral is contact from the team and a history is taken over the phone.

PROCESS OF ADMISSION

On admission, a full psychiatric assessment is undertaken including a mental state examination. Physical well-being is managed by a GP who accesses the unit five days a week and also carries out a six-month physical review. A collateral history is ongoing. The consultant psychiatrist makes the decision to admit a patient and has communication with the patient regarding the admission wherever possible and contact is encouraged with family members. The consultant psychiatrist reviews new patients within 24 hours and the initial treatment plan is documented in the notes that are shared between all disciplines.

CARE PLAN

The care plans are all nurse led. They are based on the Roper Logan Tierney model, which identifies needs and has clear goals and objectives. The patient's key worker is responsible for updating and reviewing the care plan.

It is unusual for people to be discharged from this unit although there is one female patient currently in the unit for a specified period of time and there is close liaison maintained with all the services involved in her care.

ACCESS TO THERAPY

There is no psychologist or social worker input to the ward. In the past there was access to occupational therapists who carried out seating assessments on all the patients. This led to personal chairs being purchased to meet their needs. There are two consultant psychiatrists who have access to beds and they carry out a weekly review.

A GP also provides cover. There is access to physiotherapy, a chiropodist, dentist, opticians and a hairdresser.

ACCESS TO THERAPEUTIC PROGRAMMES

The emphasis on the ward is on maintaining physical care and well-being. Wherever possible patients are taken out for walks and time is spent in general conversation with them. On occasions voluntary services come in and play music, which is well received by patients.

CLINICAL RISK MANAGEMENT

There is a comprehensive safety statement that clearly looks to manage all aspects of risk within the unit. There are various policies in place in need of review as the majority of them were last reviewed in 1995. Serious untoward incidents are recorded on the appropriate forms.

UNIT MANAGEMENT

There are no transfers, temporary or long term from this unit. There are only six patients who are currently mobile within the unit and they are given escorted access to the garden areas.

There are seven nursing staff on duty during the day and three at night. There is a central rostering system in place although there are some core staff within the unit. There are two household staff. Maintenance of the ward is carried out by the maintenance department on site. Visiting times are flexible. Meals are at set times and there is availability of snacks and drinks in between.

SERVICE USER INVOLVEMENT

There is some information available on treatment and therapies and patients' rights. Some information leaflets are also available. There is a complaints procedure in place and the staff interviewed pointed out that if any carers were unhappy with the care, they meet with the medical or nursing staff. There is also access to advocacy.

RECORDS

Records are shared between all disciplines. There are well-maintained sets of notes that include treatment plans and reviews of nursing care plans. There is also a separate file in which the GP writes, pertaining to people's physical state. Generally the medication charts are up to date although some needed rewriting. The chart of a Temporary patient was reviewed and there were clear reasons stated as to why the patient was Temporary and that all other options had been considered.

ENVIRONMENT

This was a 20-bed psychogeriatric ward situated in a psychiatric hospital. There was access to a maintenance programme. There was disabled access and the unit was bright with plenty of natural light. It was reported by the nurse in charge that they are looking to carry out some minor works within the ward which would provide more suitable accommodation for the patients and a better working environment for the staff.

There was a separate visitor's area within the ward, which was a nice facility. The bedroom areas were situated in two main dormitories. They contained curtains and everybody had their own wardrobe space. Toilets and bathrooms were in a good condition. There were two bathrooms that had modern baths that require no manual handling. There was a lounge area and most of the patients have their own individual seats following the occupational therapy assessment. The nursing station was situated centrally in the main corridor of the ward. There was also a nursing station in the dormitory areas. The clinical room contained all the appropriate medical equipment and storage for drugs. There were separate staff facilities and there was appropriate storage within the unit.

STAFF TRAINING

There is access for staff to attend courses and there is some financial assistance made and time off.

Cavan/Monaghan, Louth/Meath

UNIT 15

Date of inspection: *21st July 2005*

Number of beds: *15 integrated*

DESCRIPTION

This unit is described as a 15-bed acute admission unit. The unit has an open door policy. On the day of inspection, there were only two in-patients.

REFERRAL

The sources of referral are the home-based treatment team and the rehabilitation team. The process of referral is the team meeting; unit staff attend this meeting and referrals are discussed. The mechanism of assessment prior to referral is a discussion at this meeting that leads to an assessment.

PROCESS OF ADMISSION

People under the age of 16 are not admitted. On admission a full clinical and social assessment is carried out. The assessment also includes a physical examination and the collection of a collateral history. It is a team decision whether to admit a patient to the unit. Communication with the GP is through the home care team and the GP is always informed if a patient is involuntarily detained. The initial treatment plan is compiled within the first 48 hours of admission. The consultant psychiatrist reviews the patient at least two to three times a week. Initially, on admission, a patient is placed on one-to-one special nursing. There is a primary nurse system in operation.

CARE PLAN

The care planning on the unit is nurse led and revolves around the clinical and social assessment. It is reported that it is needs identified and involves appropriate people in meeting the needs. There are goals and objectives identified and the risk assessment is incorporated. The patient is encouraged to be part of their care.

On discharge, the unit-based team link with the home-based team, who will communicate with all parties about the impending discharge.

NURSING PROCESS

The service has developed its own assessment based on a Functional Analysis of Care Environment (FACE) assessment. It is regarded as appropriate to needs and is implemented by a primary nurse.

ACCESS TO THERAPY

Each sector team has access to a psychologist, occupational therapist and social worker. There are three consultant psychiatrists who have admitting rights to the unit.

ACCESS TO THERAPEUTIC PROGRAMMES

There is little therapeutic activity facilitated within the unit. It was reported to the Inspectorate that a room could be converted from a dormitory into an activity area, which would then enable the staff to provide some activity. At the moment the patients go to a drop-in centre on site or to the industrial therapy unit.

CLINICAL RISK MANAGEMENT

There is a policy available on clinical risk management. It is reported that there is an alarm system in operation, but the nursing staff interviewed said this needs to be upgraded. It was reported that there are policies on alcohol and illegal drugs, patients absconding, the management of violent episodes and the procedure on giving medication without consent. However when the Inspectorate reviewed these policies they were all dated for 1995 and thus in urgent need of review. There is no mechanical restraint used though there is a manual restraint policy.

Staff are trained in restraint techniques, which include de-escalation and breakaway techniques. All staff receive ongoing training in cardio-pulmonary resuscitation and other mandatory training.

There is a clinical risk assessment in each of the patient's charts. Any serious incidents are recorded on the appropriate forms and sent to the central office.

UNIT MANAGEMENT

Patients are not temporarily transferred to other units. On the day of inspection, there were only two in-patients. Occasionally people are transferred on a longer-term basis to the psychogeriatric unit within the hospital. There is an open door policy on the unit and if patients are Voluntary they are allowed off the unit. The unit is used also for day patients. There are a number of people accessing the unit for various reasons. Some patients attend industrial therapy and visit the unit at lunchtime. The unit tries to encourage daily contact with certain people and they may come into the unit for their meals. Also, if people are working and the community nurse can't access them to administer depot injections they come to the unit in the evening for their depot.

There are three staff on duty during the day and either three or four staff on duty at night. It is a structured shift system, which seems somewhat inappropriate to the needs of the unit. It was stated on the day of inspection there are only two in-patients and yet there are still three or four staff on duty at night. The unit is staffed via a central rostering system although there are some core staff. There is one household member of staff on duty during the day. The female staff wear a uniform and it was reported that it is policy to do so.

Maintenance is carried out by the maintenance department on site and it was reported that it was generally a good service. It was reported that out of hours the unit becomes the switchboard for the hospital. There are open visiting times and visitors are encouraged to come to the unit. If a patient is well enough they can make their own snacks and drinks during the day and there are set times for meals.

SERVICE USER INVOLVEMENT

There are some leaflets available explaining treatments and therapies. Information is available on patients' rights and the complaints policy. There is access to advocacy.

RECORDS

The files are shared by all disciplines. They are in good condition and legible and clear. They contain appropriate signatures. There are progress reports from allied health professionals and a treatment plan that is regularly reviewed. Medication charts are all signed and dated, legible and use generic names.

ENVIRONMENT

This was a fifteen-bed acute admission unit on the ground floor. It was situated in the grounds of a psychiatric hospital and there was an ongoing maintenance programme. There was plenty of natural light, ventilation and the décor was good. There were information boards with up-to-date information. There is access to a garden and a veranda area.

For the purposes of assessing referrals there was an interview office separate from the unit. The bedroom areas were predominantly in dormitories although there was one single room. There was adequate privacy in the dormitories, with wardrobe space. It was reported that there is currently potential to convert a dormitory area into an activity area.

Toilets and bathrooms were in good décorative order, there was free access, and they were gender specific. There were overriding locks on the doors. There were two lounge areas on the unit, one for smoking and one non-smoking both of which were in excellent condition with comfortable furniture. The nursing station was centrally located in the main corridor of the unit. There was adequate space for report writing and it was accessible. There was no IT available to the unit and it was reported that the alarm system needs updating.

The clinic room was also central in the main corridor. It contained all the appropriate medical cardio-pulmonary resuscitation equipment and storage for medication.

There was adequate storage for residents' possessions and files and records.

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STAFF TRAINING

It was reported that there are a number of courses available at degree and diploma level and also at local level and mandatory training. Funding is available and time is given for the staff to attend training courses.

WARD 8

Date of inspection: *21st July 2005*

Number of beds: *14*

DESCRIPTION

Ward 8 is a 14-bed male psychogeriatric ward located on the campus of St. Davnet's Hospital. On the day of inspection, there were three patients on Temporary status, one Person of Unsound Mind (PUM) and one person who was a Ward of Court. All patients were aged 65 years and older.

REFERRAL

This ward is under the clinical direction of the care of the elderly team. Prior to admission the team discusses all referrals. All admissions to the ward are planned and all patients are diagnosed with dementia with behavioural problems. There are admissions from the community, nursing homes, and hostel accommodation.

PROCESS OF ADMISSION

The team discusses all admissions. A full review is completed prior to admission. A GP visits the ward daily and completes the six-monthly physical reviews.

CARE PLAN

There are no formal multidisciplinary care plans in place on the ward.

NURSING PROCESS

There is a nursing care plan in place. This contains a risk assessment and is appropriate to the needs of the patient group. There is no key nurse system in place. Observation levels are decided on clinical need, although there are no defined levels.

ACCESS TO THERAPY

The consultant psychiatrist or medical team member visits the ward weekly and as needed. There is a GP in attendance daily. The chiropodist and physiotherapist visit as requested. Referrals to psychologist, social worker and occupational therapist are made as required.

ACCESS TO THERAPEUTIC PROGRAMMES

There are no structured individual programmes in place. Some patients are accompanied on walks within the grounds, other leave unsupervised. A large percentage of the patients are physically dependent and have cognitive impairment.

ECT

No patients are in receipt of ECT.

SECLUSION

Seclusion is not in place on the ward.

CLINICAL RISK MANAGEMENT

The patients are at risk of falling due to their age, decreased mobility, and diagnosis. A number of patients require toileting and full nursing care. All necessary equipment is in place to assist staff.

A number of residents are restrained in chairs by belts. Cot sides (padded and unpadded) are used at night. There is no policy on prescribing and review of restraint.

Training is offered to staff throughout the year.

UNIT MANAGEMENT

The nursing staff are rostered centrally but are consistent. The ward will lodge patients from hostels who may attend for appointments at the general hospital. Meals are at regular intervals. Four patients require assistance with feeding. All food is prepared on the campus and it is a cook-chill system. Maintenance is provided in house. There is no waiting list for admission.

SERVICE USER INVOLVEMENT

Service users do not have the capacity to make complaints. Family members voice complaints to nursing staff. Complaints are processed in accordance with HSE North Eastern Area policy. Advocacy services do not visit the ward. All patients had received letters regarding refunding of monies paid from December 2004 to July 2005.

RECORDS

The medical and nursing notes reviewed during the inspection were current, legible and contained regular reviews by medical and nursing staff. There was clear evidence of timely mental state reviews. The card index system was in order and the current list of medications was in order and had been reviewed recently. There was no signature bank in place for any staff members. Nursing staff were only initialling administration of drugs.

ENVIRONMENT

The ward was located on the ground floor. On the day of inspection, it was undergoing renovations. These renovations would provide additional bed space, a dining room with direct access to a veranda and enclosed garden. It would also result in a new sluice room and upgrading of the toilet area. It was hoped the renovations would be completed by October 2005. The nightingale ward area (11 patients) offered a minimum level of privacy. There was one room, which accommodated three patients.

CAVAN/MONAGHAN

LAUREL VIEW

Date of inspection: *20th July 2005*

Number of beds: *11 integrated*

DESCRIPTION

Laurel View is an 11-bed community residence with 24-hour nursing staff supervision. It was opened in 1990 and is situated on the edge of town. There are currently two male residents and eight female residents.

REFERRAL

There is a monthly residence meeting for the Cavan/Monaghan Catchment. The process of referral is a discussion at this meeting and agreement is made on the most appropriate person to go to the residence. The person is gradually introduced to the residence with an emphasis on meeting the staff, other residents and familiarising themselves with the day-to-day running of the residence.

PROCESS OF ADMISSION

There is an admission policy in existence and the only exclusion criterion is if a person's physical needs are such they cannot manage the stairs. The resident is introduced to the residence on a gradual basis so a care plan and assessment is already identified on admission. The care plan is reviewed on a regular basis. The residents' physical well-being is managed by a GP of which there are two in the town. The decision to admit is made at the monthly meeting by a consultant psychiatrist and team. The communication process is very clear and the residence staff encourage family members to keep in contact. The Inspectorate was informed that a consultant psychiatrist is available to review the residents each week and there is an initial treatment plan documented in the case notes. However, there is no key worker system. It was reported that this has been discussed in January 2005 and is in the plans for this residence. It was also reported that recently some residents from another residence in the area were transferred, so they have allowed a settling-in period.

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CARE PLAN

The care plans in the residence are nurse led. They are based on FACE assessment and are documented in a shared file. Care plans are needs identified and they involve the appropriate person in meeting these needs. Care plans are reviewed on an ongoing basis. There was also documented evidence that a resident partakes in the care planning process and signs the care plans.

NURSING PROCESS

The assessment used in the residence is the FACE assessment which is appropriate to the needs and does contain elements of a risk assessment.

REHABILITATION TEAM

There is no access to a clinical psychologist, occupational therapist or social worker. There is one consultant psychiatrist responsible for the residence and there is a weekly review. All residents are registered with a local GP and they also have access to a chiropodist, dentist and optician.

INVOLVEMENT IN REHABILITATION PROGRAMMES

This is an ageing population and their needs are changing. If an individual is physically capable of going out, they are encouraged to go to town and take part in social activities. However, the majority of the residents are at an elderly stage of their life; they help with household chores and participate in any of the activities occurring within the residence. It was also reported to the Inspectorate that there are two voluntary agencies that offer support to the residence. They are Castleblaney Mental Health Association who accompany residents out and also the Blaney Blades who accompany residents to social functions in the town. These organisations also fund-raise for the residence.

CLINICAL RISK MANAGEMENT

There is evidence of policies on clinical risk management and also individual risk assessments. Incidents are recorded on appropriate forms and there is a safety statement which is provided by the safety officer within the hospital.

UNIT MANAGEMENT

The skill mix within the residence is all qualified staff. There are two staff on duty during the day and one at night. The residence has its own dedicated staff team. There is one household staff. The ethos of the residence is to provide a homely environment and to promote as much independence as possible. Maintenance is carried out by the hospital maintenance in St. Davnet's in Monaghan although there is emergency support from the hospital next door.

HOUSE RULES

The main rules are around smoking – there is a specific area for smoking within the residence. Visiting times to the residence are open. Residents are able to leave the residence unsupervised. They are asked to tell staff when they are going out but this does not always happen. They are not required to be out during the day.

The main meal of the day is provided and cooked by St. Mary's Hospital. Other meals are prepared within the residence. Some of the residents help in preparing the meals. Residents have access to the kitchen to make snacks and drinks.

Residents are not required to go to bed or get up at certain times although they are encouraged to get up for breakfast.

Most of the sleeping accommodation is shared and the staff tend to move people around due to some of the residents being more vulnerable and therefore open to exploitation by the other residents.

Residents do not manage their own finances. They all have post office accounts or bank or credit union accounts and are allocated money on a daily basis. There is a policy in place on financial management. Residents buy their own clothes in the local shops. They also have access to a utility room within the residence and there is also dry cleaning provision once a week.

SERVICE USER INVOLVEMENT

There is information on treatment available. All residents are eligible to vote. There is a complaints procedure in place. There are no formal meetings between the staff and the residents although there is some general discussion over meal times.

RECORDS

The records within the residence are combined. Residents can access the file and do so to sign the care plans. The files are neat and tidy, contained appropriate signatures but did not have the title of the personnel or the name printed. There was no evidence of any progress reports from other health professionals although there are sections available in the notes. The treatment plan is prescribed by the nursing team and is regularly reviewed. There are short written interventions from the medical staff in the notes that were reviewed.

There was no evidence of any of the residents being on a self-medication programme. Medication sheets were reasonably up to date although some needed rewriting.

ENVIRONMENT

There was a regular maintenance programme in place. The hygiene and décor of the residence was good. The furniture looked extremely nice and contributed to a homely environment. Attention was given to maintaining people's privacy and dignity. There were identified problems with the stairs; all the accommodation was upstairs. The residence accommodation consisted of single bedrooms and three-bed dormitories which had individual space. There was also a dining area, two lounge areas, a smoking lounge, a kitchen and an appropriate number of toilets and showers.

STAFF TRAINING

There is mandatory training available for the staff and people can also access long-term courses. It was stated that in some cases staff would fund the course themselves and would only be reimbursed if they passed the relevant examinations.

LISDARN LODGE, CAVAN

Date of inspection: *20th July 2005*

Number of beds: *15 integrated (8 male, 7 female, 1 respite)*

DESCRIPTION

Lisdarn Lodge was opened in 1995. The building is a large two-storey house with a bungalow-type extension that was added in 1994. It is situated in mature, private grounds in the Cavan General Hospital campus. It provides 24-hour care to residents who have severe and enduring mental illness and is a component of the Community Rehabilitation Service. All residents are discharged patients. The respite bed is occupied by a patient of the Assertive Outreach Team (AOT). The age range of residents is between 38 and 81 years.

REFERRAL

Over half of the residents came to the residence following the closure of a long-stay ward in St. Davnet's Hospital, Monaghan in 1995. Subsequent referrals have come through the community rehabilitation team, following a FACE assessment and discussion at the regular residences' meeting, which is attended by the nurse in charge of the residence.

PROCESS OF ADMISSION

All admissions to the residence are known to the community rehabilitation team and have a comprehensive multidimensional assessment prior to admission. The respite bed is used on a planned basis by the AOT. A full psychiatric and physical assessment is completed following admission and a nursing care plan is put in place. A key worker is appointed for every two residents and is responsible for care plans, personal budgeting and contact with the family.

CARE PLAN

Each resident has a care plan with agreed goals, which is signed by the resident. This is reviewed on a two- to three-monthly basis by the nursing team and a full FACE assessment is completed yearly.

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NURSING PROCESS

The Orem model was in use, but the model currently in use is closely linked to the FACE system of assessment. It is appropriate to the individual's needs and contains a risk assessment. The nursing staff do not wear identification badges as they are well known to residents.

REHABILITATION TEAM

A multidisciplinary community rehabilitation team is in place. A consultant psychiatrist visits every two to three weeks and reviews the residents on a six-monthly basis. Residents are registered with a local GP. Most are accompanied on visits. Other professionals, such as chiropodists, are accessed in the community.

INVOLVEMENT IN REHABILITATION PROGRAMMES

None of the residents attend day services off site. Some individual needs-based programmes are provided on site. These focus on developing skills such as literacy and budgeting, and other basic life skills. A behavioural therapist has been involved in designing a specific programme for one of the residents. Nine of the residents are over 65 years of age and some are retired. Several residents engage in household tasks. Other activities on site include reminiscence therapy, exercise, newspaper reading and games.

UNIT MANAGEMENT

There are no temporary transfers to or from other units. The residence is not used for any other purpose. The residence is self-staffing. There are 7.5 whole-time equivalent full-time nurses, one full-time and one part-time household staff and a staff member who does the laundry on a part-time basis. There is one nurse on duty from 0800h to 2000h, two nurses from 0800h to 1700h. One nurse is on duty from 0800h to 2000h with security backup from the general hospital and an on-call Assistant Director of Nursing in St. Davnet's Hospital. There is an induction process for new staff and students. The ethos of the residence is to provide a homely atmosphere with emphasis on quality of life, choice and developing the potential of each resident. There is a suggestion box for residents but this is rarely used. The maintenance budget is held in St. Davnet's Hospital.

ETHOS

The ethos of the unit is to provide a homely atmosphere for residents. All policies and procedures available in the residence are common to the service and not specific to the residence.

HOUSE RULES

The rules of the residence are designed by the staff with some consultation with residents. They are reviewed at staff meetings. Visiting times are flexible with all residents having visitors from time to time. Most of the residents are allowed to leave the residence unaccompanied but are required to check in and out with staff. Household staff prepare breakfast and evening meals with the lunch coming from the main hospital. Residents are involved in planning the breakfast and tea menus. There is no smoking allowed in bedrooms. Residents are not required to go to bed at set times.

The pensions of all the residents go to St. Davnet's Hospital, where rent is deducted. Staff collect the balance of the monies and monies for household costs are deducted. The remainder is kept in individual purses in the nurses' office. All the residents have credit union accounts. Residents buy their own clothes in local shops and are accompanied by staff. Residents have access to a utility room for laundry if they choose to. Most residents do not access local facilities unaided. Because of distance and lack of public transport, they normally use a taxi to go to the town.

SERVICE USER INVOLVEMENT

There are some information leaflets available but most of the residents are given verbal information on treatment and therapies and their rights. There is a complaints policy available. There is no formal measurement of residents' or their families' satisfaction with the service. There are informal talks

with staff about outings and holidays. There is an informal community meeting held weekly. No advocate visits the residence.

RECORDS

The residents' charts were neat and manageable. They contain dated and signed progress reports from nursing staff and contain care plans. Apart from the respite resident, no resident is discharged from the residence so no discharge plans are in place. Residents do not write in their files nor do they access them.

There is no policy of encouraging those who can to self-medicate. Prescription and administration sheets were signed, dated and legible although some of the signatures were not identifiable and no signature bank is available.

ENVIRONMENT

The residence was pleasant and homely and the décor of the building was generally of a high standard. There were five single bedrooms and five double bedrooms. They were pleasantly décorated and all residents had personal belongings in their rooms and adequate storage space. There were two lounges, a dining room, and a kitchen, all of which were of adequate size and nicely décorated. The nursing office was small and cramped. The smoking room was badly discoloured and poorly ventilated and was in need of redecoration. There was access to a patio area at the rear of the house and there were extensive gardens.

STAFF TRAINING

Some in-service training is available to staff but staff find it difficult to access information on courses and their availability. There is no computer or Internet service available to the staff.

ST. JUDE'S

Date of inspection: *21st July 2005*

Number of beds: *15*

DESCRIPTION

St. Jude's is a two-storey house located on the campus of St. Davnet's Hospital. It was the former nurses' home. It is home to 11 residents and offers placement for up to four respite residents. It is under the clinical care and direction of the community rehabilitation team . Many of the residents are former patients of St. Davnet's hospital. Their age profile is from 41 years to 69 years.

REFERRAL

All referrals to the residence are processed through the community rehabilitation team.

PROCESS OF ADMISSION

The residence's primary purpose is rehabilitation. There is an admission policy and there are four dedicated respite beds that are used for a variety of reasons. There are written guidelines on using the respite places. The consultant psychiatrist or NCHD visit the residence weekly.

CARE PLAN

There is a comprehensive care plan in place for each resident. The care plans are in a single folder, subdivided into sections, resulting in a detailed typed case history, FACE assessment and identified care plan. There was evidence of additional notes from occupational therapy in the plans reviewed. The file also contains a typed medication history and lists current medications.

REHABILITATION TEAM

The consultant psychiatrist visits weekly. The occupational therapist is currently involved with two residents. The community rehabilitation team coordinator visits fortnightly. Nursing staff attend a monthly review of meeting of residence residents. All

residents are registered with a GP and visit as required. There is one staff nurse and one domestic staff on duty by day and one staff nurse on duty by night.

INVOLVEMENT IN REHABILITATION PROGRAMMES

A number of residents attend industrial therapy on site. Other residents, due to their age and needs, are not involved in work-based programmes and remain in the house during the day.

UNIT MANAGEMENT

The residence is self-staffed. It provides a mixture of rehabilitation and continuing care programmes. There is no formal method of measuring satisfaction in place. Three residents were transferred to another high support facility with increased staffing ratio in 2004. A number of residents were on holiday in Donegal this year.

HOUSE RULES

House rules are designed by staff and each individual is informed of them on admission. Residents do not have a front door key but the door is locked only at night. Residents can lock the bathroom door and some residents can lock their bedroom doors. Residents are encouraged to let staff know when they are leaving the building. Visitors are welcomed.

The main meal is prepared by the central kitchen and is delivered daily. Breakfast and evening tea are prepared on site. Some residents are involved. Residents have free access to a kitchenette known as "the pantry" to make drinks and snacks during the day.

All of the bedrooms were single rooms located upstairs. Each room was a good size with a hand basin in place. The furniture and décor was of a good standard and residents had personalised their own areas. There were no set bedtimes or rising times.

One resident is fully independent with money management. All other residents are in receipt of a daily allowance. Some lodge this allowance into a post office or credit union account. Money is collected by the CNM2 and lodged in the main administration office. Residents contribute €18 a week for household fund. All residents were in receipt of a letter detailing recent stoppage of charges. Some residents use the local community facilities although this is limited.

SERVICE USER INVOLVEMENT

Oral information on treatment is provided on request. Residents are registered to vote. Complaints were stated to be rare and the residence does not have a community meeting.

RECORDS

The records reviewed were of a high standard and showed evidence of a treatment plan and evaluation. The medication flow chart is an excellent idea and demonstrates active case reviews. There is a need for a signature bank for all staff writing into the records.

One resident is self-medicating. There was no resident in respite care on the date of the inspection.

ENVIRONMENT

The building was pleasant; the décor was of a high standard and not institutional in style. The dining room had been recently repainted. Each resident had a single room, which offered maximum privacy. There was also a sitting room, dining room, visitors' room, internal smoking room and utility room. Residents had free access to the utility room. There was a staff toilet in the residence.

WOODVALE

Date of inspection: *21st July 2005*

Number of beds: *16 integrated*

DESCRIPTION

Woodvale is a community residence with 24-hour nursing staff supervision situated in the grounds of St. Davnet's Hospital, close to the town. There are two respite beds and currently there are six male residents and eight female residents.

Cavan/Monaghan, Louth/Meath

REFERRAL

The community rehabilitation team refer people for respite and for permanent transfer to the residence. There is a six-weekly meeting of all the residence and community rehabilitation staff which identifies suitable candidates for the residence.

PROCESS OF ADMISSION

Once a person is identified for admission there is a gradual process of familiarisation with the residence. The only exclusion criterion for admission is acute illness. The rehabilitation programme is linked very closely with the community rehabilitation team. There are two respite beds, one for a person with more acute needs and the other is for rehabilitation needs.

A full psychiatric assessment is undertaken. Physical needs are managed by the GP. The decision to admit a person to the residence is taken by the team. Staff encourage communication with the resident and they try to maintain communication with family members. Letters have been sent to all relatives informing them of their transfer to this residence.

There is one consultant psychiatrist with responsibility for residents and there is a general review every six months. The initial treatment plan is documented in the nursing notes and there is a key worker allocated.

CARE PLAN

The assessment is mainly nursing and the staff use the FACE assessment. It is needs identified and indicates goals and objectives. Care plans are reviewed on a regular basis by a key worker.

The residence has been open for less than a year and the majority of the residents were long-stay patients within St. Davnet's Hospital, so it is too early to say whether people will be discharged from this residence. The staff member interviewed estimated that one or two of the residents could move on to lower levels of support.

NURSING PROCESS

The assessment tool used is the FACE which is appropriate to the needs of the residents and is implemented by nursing staff. The assessment contains some elements of a risk assessment.

REHABILITATION TEAM

There is no access to clinical psychology. The residence is trying to negotiate some time with the occupational therapists who are in short supply. It is hoped that some activities could be operational in September. There is access to a social worker. There is one consultant psychiatrist responsible for the residence who maintains contact and reviews each resident on a six-monthly basis. Physical needs are managed by the GP. The GP keeps their own record of their interventions within the residence.

INVOLVEMENT IN REHABILITATION PROGRAMMES

The majority of the residents were long-stay patients within the hospital. Some go to the industrial therapy department within the hospital but there does not appear to be much for the residents to do.

CLINICAL RISK MANAGEMENT

There is evidence of policies on clinical risk management and individual risk assessments. There is auditing of serious untoward incidents.

UNIT MANAGEMENT

There were three staff on duty during the day and sometimes up to four. There were two at night, one male and one female. The unit has its own dedicated staff and there are two household staff on duty during the day.

The ethos of the residence is to promote independent living as much as possible. There are appropriate policies and procedures present within the residence. Maintenance is carried out by the maintenance team in St. Davnet's Hospital.

Cavan/Monaghan, Louth/Meath

HOUSE RULES

The main rules centre around smoking and the residents who smoke are encouraged to do so outside, though there is a dedicated smoking room within the residence. However, it was pointed out that there is an outside area which, if a temporary shelter could be erected, would provide a more suitable venue. Visiting times to the residence are flexible. Residents all have their own individual bedrooms and can lock the doors. The staff have a key which overrides the locks. There are locks on the bathrooms and residents are allowed to leave unsupervised. It was noted on the inspection that a number of the bedroom doors were locked and the reason given for this was that some of the female residents are deemed to be disruptive and take clothes out of the wardrobes. Staff hoped to develop a different strategy for this problem which would allow the bedrooms to remain open.

Meals are prepared on site and delivered to the residence from the main kitchens in the hospital. Residents are not involved in menu planning or shopping. They have access to the kitchen and drinks and snacks are available during the day.

Residents are not required to go to bed or to get up at certain times. They are prompted to be up for breakfast. The furniture within the residence was of an extremely high standard.

The residents do not manage their own finances. Patient's money is delivered to the residence and given out by staff on a daily basis. Some of the residents have post office accounts and they are encouraged to save. They are all in receipt of benefits. It was noted that residents had been charged for their keep during the last year and the administrative staff have subsequently reimbursed the money that was taken. Residents can buy their own clothes and have full use of the utility room with help from staff.

SERVICE USER INVOLVEMENT

There is some information on treatment available. Residents all have the right to vote. There is a complaints procedure in place and most complaints are dealt with locally.

RECORDS

The case notes are shared between disciplines. They are extremely detailed and contain FACE assessments. There is a section for all disciplines to write in and the nursing care plans are reviewed on a regular basis. The medical interventions consist of the six-monthly reviews with little else written by the medical staff. There is evidence of progress reports from other health professionals if they are involved in the residents' care. The medication prescriptions are up to date. There are no people on self-medication programmes although this may be planned in the future.

ENVIRONMENT

This was a modern building that had only been opened last year. Maintenance was provided on site. The hygiene was good and the décor was excellent. All furniture was appropriate and of an extremely high standard. All residents had their own single bedroom which had a sink. The bedroom doors were lockable. The staff had an overriding key. All but four of the bedrooms were on the ground floor. The residence had 16 single rooms, two lounge areas, one dining room, kitchen, nursing office, clinical room and an appropriate number of toilets and bathrooms.

STAFF TRAINING

There are courses available in Ardee for the staff. The member of staff interviewed said that the courses were accessible although it can be difficult at times to release people due to shortages of staff, especially during the summer period.

ST. BRIGID'S HOSPITAL, ARDEE

OUR LADY'S WARD

Date of inspection: *19th July 2005*

Number of beds: *21 female*

DESCRIPTION

Our Lady's Ward is a single-storey ward in St. Brigid's Hospital. The age range of the patients is from 50 to 90 years. The unit provides a mix of continuing care, elderly care and emergency care. The unit is a locked unit but a number of the patients can have unaccompanied access to the outside when they wish. Two patients are on Temporary status, two are Wards of Court and the remaining patients are on Voluntary status. Three consultant psychiatrist led teams admit patients to this unit. There is one respite or emergency bed.

REFERRAL

Referrals come from the three sector teams. Some of the admissions come directly from the acute admissions unit. Others are referred from supported residences in the catchment area. Respite is sometimes provided to residents of the supported residences, on a planned basis. Occasionally, a patient is lodged overnight in the unit from the acute admissions unit. All new admissions to this unit are already known to the service.

PROCESS OF ADMISSION

A consultant psychiatrist makes the decision to admit someone to the unit. Prior to admission, the patient is assessed by the consultant psychiatrist or NCHD or, in the case of admission for respite, by the community mental health nurse. Within days of admission, a full psychiatric and physical assessment is carried out by the duty NCHD. A nursing assessment is also carried out.

CARE PLAN

There is no multidisciplinary care planning system in use on this ward. A nursing care plan is in use, which focuses on activities of daily living. This plan is reviewed on a fortnightly or monthly basis.

NURSING PROCESS

The Roper Logan Tierney nursing model is in use and primary nurses are allocated to groups of patients. There is no comprehensive risk assessment in use but pressure sore prevention risk assessments and nursing dependency level assessments are used for elderly, physically dependent patients. There is no policy on observation. Staff wear uniforms and name badges.

ACCESS TO THERAPY

There is no rehabilitation team and there is no occupational therapist assigned to the ward. Referrals are sometimes made to social workers prior to discharge. A psychologist can be accessed if necessary. The consultant psychiatrists visit the ward weekly or fortnightly and review patients every six months. An NCHD contacts the ward on a daily basis by phone and visits when necessary. Medical and surgical consultations take place at the Louth or Drogheda hospitals and patients are transported there by taxi or hospital bus, accompanied by a staff member. Staff can access laboratory results quickly.

ACCESS TO THERAPEUTIC PROGRAMMES

A weekly Sonas group is run by nursing staff. Four nursing staff have been trained in reminiscence therapy and are about to begin a service to patients on this ward. Nursing staff also run a daily exercise programme, designed by a physiotherapist. Relaxation, massage and aromatherapy are also provided.

ECT

ECT is not provided on this ward.

SECLUSION

Seclusion is not carried out on the unit and there is no seclusion room.

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CLINICAL RISK MANAGEMENT

A clinical risk management policy is currently being updated. Risk management focuses on the prevention of pressure sores and falls. Cot sides and safety belts are used for safety purposes when authorised by a consultant psychiatrist. There are two pinpoint personal attack alarms in use on the unit and a response is organised from other wards. There are policies on alcohol and illegal drugs, giving medication without consent, patients going missing and the management of violent episodes. The personal belongings of patients are not searched. Serious incidents are recorded and this data is collected for action and for audit purposes.

UNIT MANAGEMENT

The door to the unit is locked in order to prevent some of the patients from wandering. Several patients are allowed to leave the ward unaccompanied on request. There is central rostering of staff to the unit. The staff complement is five nurses by day (from 0800h to 2000h) and two nurses from 0800h to 2000h. There is usually one ward attendant on duty on each shift. There is no ward clerk although staff expressed the need for one. Phlebotomy services are provided by the NCHD. There is no waiting list for the unit. One patient is currently awaiting appropriate discharge to a hostel. Newspapers, TV and radio are provided. There is no CCTV and the ward is not used for other purposes. The maintenance service to the unit is good. Visiting times are flexible. Drinks and snacks are provided at set times during the day. Meal times are 0830h, 1220h and 1630h and sandwiches are provided at 2100h.

SERVICE USER INVOLVEMENT

There is a notice board for patients with information about their primary nurses. There are many relevant information leaflets available. Information is posted about the complaints' policy and a suggestion box is available. An informal community meeting is held at weekends. No advocate calls to the ward.

ENVIRONMENT

The ward had been recently painted and was in good repair. The ward was accessible for people with physical disability and the corridors were wide. The noise level was low. There was a smoking, room, which was well ventilated. The majority of patients slept in a large dormitory area. Their beds were surrounded by curtains and they had locker and wardrobe space. There was a 5-bed area close to the nursing station which was used as a higher observation area. There was only one single room available. There was no access to an outside garden although there was potential to create a small garden outside the ward and to provide easy access to it. Bathrooms were fitted with high/low bath and shower.

RECORDS

The patients' charts were tidy and manageable. The front cover contained the patients' name, date of birth and any allergies. Entries were all dated and signed but not all signatures were legible, nor was the person's title always used. The charts contained treatment plans, progress reports and consultant reviews.

The nursing notes were signed, dated and legible but full names and titles were not always used. The charts that were inspected contained no entries from social workers, occupational therapists or psychologists. A card index system was used for medication. The prescription and administration sheets were signed and dated but some of the signatures were not easily identifiable. The generic names of drugs were used. The discontinuation of medication was signed and dated.

STAFF TRAINING

A training programme is in place for nursing staff and records of training are kept on the ward. Staff have received training in control and restraint, de-escalation, breakaway, cardio-pulmonary resuscitation and a range of training programmes relevant to care of the elderly.

ST. ITA'S WARD

Date of inspection: *19th July 2005*

Number of beds: *13 male*

DESCRIPTION

This unit is described as 13-bed long-stay locked unit for male patients. On the day of inspection, there was one patient on Temporary status.

REFERRAL

The sources of referral to this unit are the residences in the area and the acute ward in the hospital. The process of referral is consultant psychiatrist to consultant psychiatrist initially, followed by the ward team discussing the case with a consultant psychiatrist and undertaking an assessment.

PROCESS OF ADMISSION

On admission, a full psychiatric assessment including a mental state examination is carried out. There is an initial physical examination which is repeated every six months and a collateral history is obtained. The person making the decision to admit to the unit is a consultant psychiatrist in conjunction with the CNM2.

The initial treatment plan is discussed with the patient by the admitting doctor and nurse. It is reported that some patients have good contact with their family, and staff try to encourage as much contact with family as possible. There are two consultant psychiatrists who have clinical responsibility for patients on this ward, but there are no regular reviews carried out by these consultant psychiatrists. There are two levels of observation on the unit, general and special (one-to-one). There is also a key worker system which is based on the patients being divided into groups and nursing staff are allocated to these groups.

CARE PLAN

Care planning on this unit is nurse led. There are no other contributions by any members of a multidisciplinary team. Nursing care plans are needs identified. Goals and objectives are identified and there are regular reviews of these care plans.

NURSING PROCESS

The nursing model in use is the Roper Logan Tierney model. It was reported that the unit staff have adapted the model slightly to make it more appropriate to the needs of the patient group. There are some elements of risk assessment carried out in the care plans pertaining mainly to physical well-being.

ACCESS TO THERAPY

There was no access to clinical psychology or occupational therapy. It was reported that there are day services on site and these activities are facilitated by nursing staff. There are two consultant psychiatrists for patients on this ward and they review the patients as and when requested by the nursing staff. It was reported that a number of the patients on the ward have physical needs and staff are equipped to deal with various physical ailments including wound care.

ACCESS TO THERAPEUTIC PROGRAMMES

There is little evidence of any therapeutic groups being carried out on the ward. There is an elderly population who, if they can, attend the day services within the hospital and it was reported that one patient attends the day services in Drogheda.

CLINICAL RISK MANAGEMENT

There is a policy on risk management available. There is an alarm system in operation and there are policies on alcohol and illegal drugs, patients missing from the ward, the management of violent episodes and giving medication without consent.

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It was reported there is little aggression or violence on the unit. There is training available for the nursing staff in control and restraint techniques. There is training available for cardio-pulmonary resuscitation and other mandatory training. Staff receive regular training updates.

The risk assessment documented in the patients' chart pertains to mobility and wound and pressure care. Any serious untoward incidents are recorded on appropriate forms and sent to management. However, it was reported that there is no feedback on the auditing of these forms.

UNIT MANAGEMENT

Patients are transferred temporarily due to shortages in the acute wards. There is free access to and from the unit for people who are deemed safe and able to leave the ward. The door is locked as some patients may wander. The unit is provided with staff from a central roster although there are some core staff. The roster is compiled every two weeks. It was reported that none of the patients at present are suitable to move on to other accommodation. It was also pointed out that a number of the current patients have been tried in hostels and that unfortunately the placements failed.

There is regular maintenance carried out on the unit and there was some decoration in progress on the day of inspection. Visiting times to the unit are flexible but there are set meal times. Drinks and snacks are available between meals.

SERVICE USER INVOLVEMENT

There is some information available on the treatment and therapies for the patient group, but it was reported that a number of these patients have been in the hospital for a long period of time and rarely ask for information on their care or treatment. There is a complaints policy but again it was reported by the nursing staff that it is rare to receive any complaints and there was a good rapport between the patient group and staff. Access to advocacy has recently been introduced to this ward.

RECORDS

Medical files contain the patient's name and ID number on most of the pages. Some of the written interventions by doctors are illegible. Files are reasonably tidy. Not all entries have the full names and titles of personnel and some are just initialled. There are no progress reports from allied health professionals and the only written interventions from the doctors are when they have been asked to see a patient by the nursing staff. There is an initial treatment plan but there is little follow-up or review of these treatment plans. There is evidence of six-month physical check-ups. The nursing files contained up-to-date care plans which were regularly reviewed. The files were legible and tidy and were appropriately signed and dated.

Drug charts were recently rewritten and have to be rewritten every three months. The chart of a person who has been involuntarily admitted was appropriate and contained all the necessary details and information.

ENVIRONMENT

This was a 13-bed ward for men within the grounds of St. Brigid's Hospital. There was a regular maintenance programme and the unit had disabled access. There was good lighting, ventilation and the décor was of good standard. There was access to a garden area. It was reported that the staff would prefer to have the garden fenced off to prevent some of the patients from wandering.

The bedroom areas consisted of one dormitory for twelve patients and there was an empty dormitory with one patient sleeping there due to his agitated state at night. All the bed areas had curtains and wardrobe space.

Toilets and bathrooms, one of which had recently been upgraded, were of a good standard. There was free access to the toilet areas, while the bathrooms are kept locked. The dining area was a pleasant area, it was large and had suitable space for one seating. There was a separate exercise and activity area which contained a pool table and a table football game. The lounge area had comfortable seating, a TV and music available. The nurses' station was being décorated so was not inspected. It was situated

centrally within the unit. The clinical room was at the end of the dormitory and contained all the appropriate medical equipment and the various dressings. There was adequate storage for patients' belonging on this unit.

STAFF TRAINING

Staff receive all mandatory training that they are required to undertake. There is an education centre on campus and it was reported that management are supportive of staff taking part in short courses.

UNIT 1

Date of inspection: *18th July 2005*

Number of beds: *30 integrated*

DESCRIPTION

This unit is described as an acute admission ward. There are 16 male beds and 14 female beds. The unit was locked but a new "open door" policy is to be introduced. On the day of inspection, there were four patients on Temporary status.

REFERRAL

The sources of referral to this unit are GPs, A&E, self-referrals, outpatient clinics and community nurses. Most referrals come from a GP, who provides the patient with a written referral. The sector NCHD assesses the patient during working hours and out of hours there is an on-call NCHD. In some cases the NCHD makes the decision to admit and in other cases he or she consults with the consultant psychiatrist on call.

PROCESS OF ADMISSION

People under the age of 16 are not admitted to this unit. There are people with a moderate intellectual disability admitted and clinical responsibility remains with the sector consultant psychiatrist. It is rare for anybody to be admitted solely for detoxification. If a patient was to be admitted for detoxification it is usually because of a threat of self-harm. People are admitted who are in social crisis.

On admission the NCHD carries out a full psychiatric assessment. A physical examination is also carried out and a collateral history is obtained. The NCHD makes the decision to admit a patient, sometimes in consultation with the consultant psychiatrist.

GPs are not routinely informed of an admission, though they are involved in the process if somebody is involuntarily detained. If it is decided to admit a patient then the NCHD and the nurse explains the process of the initial treatment plan and the nurse orientates the patient to the unit. A patient is reviewed by the consultant psychiatrist within 24 hours of the admission and the initial treatment plan is documented in the medical notes.

There is a night clothes policy and the medical staff make a decision as to whether a patient should be nursed in their pyjamas. It was reported that the main reason for this is if the patient is at risk of leaving the unit. It is normal procedure for people on admission to be placed on general observation unless their needs dictate a special (one-to-one) observation. One-to-one observations are rarely carried out on the unit. There is key worker system in place and nursing staff are allocated to teams pertaining to the consultant psychiatrist. The patient is allocated to a nurse on this team depending on sector.

CARE PLAN

The care plans are predominantly nurse led and are linked to the multidisciplinary team meeting. Care plans are needs identified and the patient is involved through one-to-one sessions and some patients sign the care plan. There are goals and objectives identified and the care plans are reviewed weekly. Evidence of family involvement is either on admission or if the carer reports on a patient's progress.

There is a policy in place for the discharge of patients. On discharge the GP is notified as is the next of kin and community team. The patient is given a letter to bring to their GP and is also given three days' supply of medication and an outpatient appointment. A further discharge summary is sent at a later date.

Cavan/Monaghan, Louth/Meath

NURSING PROCESS

The unit nursing staff currently use the Roper Logan Tierney model of nursing but are planning to introduce the Tidal model in the near future. The staff interviewed on this inspection said that the Roper Logan Tierney model doesn't fully meet the needs of this patient group and were confident that the implementation of the Tidal model would rectify this. On admission, the admitting nurse identifies the problem areas and devises appropriate care plans. There is no formal process of assessing risk. There is a key worker system and there is an observation policy, the majority of patients being on general observation. It is policy on this unit that female staff wear uniforms and male staff wear casual clothes.

ACCESS TO THERAPY

The psychologist can be accessed through a referral from a consultant psychiatrist. It was reported there was "occupational therapy" within the hospital and this is conducted by nursing staff. There is a referral process to access a social worker and there are two available to the unit. There is also access to alcohol and substance misuse counsellors. There are four consultant psychiatrists who have admitting rights to the unit and they review patients twice a week. The patients' physical needs are managed by the NCHD and there is access to two general hospitals in the region, one in Dundalk and one in Drogheda. There is also access to a chiropodist and dietician through outpatients, and access to a local dentist.

ACCESS TO THERAPEUTIC PROGRAMMES

There is no structured programme on this unit. If the patients are well enough they can attend the activation centre within the hospital but the majority tend to stay on the ward. There is a plan to implement the living skills programme in the near future. There appears to be very little for the patients to do on this unit. A number of the patients interviewed complained of being very bored, with little activity.

ECT

There is an ECT policy and procedure in place. There are appropriate consent forms and the consultant psychiatrist or NCHD obtains the consent of the patient. There is written ECT information available for the patient and there is a nursing procedure and checklist. There is no designated ECT nurse or consultant psychiatrist although it is planned in the future to have an ECT nurse. ECT is carried out on the unit. There are no formal waiting areas. Most of the people receiving ECT are in-patients. There is an appropriate preparation room, ECT delivery room and a recovery room.

SECLUSION

There is a seclusion policy and a seclusion register in evidence on the unit. The seclusion room is clean and appears to be safe. There is adequate ventilation and it is well lit. There is no access to a toilet. There is an observation panel in the door and communication facility for the patient. Refractory clothing is not used. The patient wears pyjamas in the seclusion area.

CLINICAL RISK MANAGEMENT

There is a policy on risk management available. There are also policies on alcohol and illegal drugs, patients absconding and the management of violent episodes. Rapid tranquillisation medication is individually prescribed by a consultant psychiatrist. There is an alarm system in operation and although there are personal alarms they are not accurate in indicating where a person in difficulties may be. If a patient refuses to take their medication there is a consultant psychiatrist review. If the patient is on Temporary status, the same process would apply and consideration given to using intramuscular (IM) medication. There was no policy on the searching of patients or their belongings.

There is a physical restraint policy and the staff informed the Inspectorate that they used control and restraint techniques which also incorporate de-escalation and breakaway techniques. There is a control and restraint form completed whenever this technique is used and it is also documented in the

patient's notes. Staff also receive training in cardio-pulmonary resuscitation and other mandatory training.

There was no evidence of clinical risk assessments in the patients' charts. Serious untoward incidents are recorded on the incident forms which are sent to the Director of Nursing. It was reported by the nursing staff there was no feedback in relation to these incident forms.

UNIT MANAGEMENT

The practice of sleeping out is common within this unit. If the unit is full, the acute unit in Navan is contacted to see if they can facilitate the admission. If not, patients are moved from the acute unit to one of the long-stay wards within the hospital. The patients have a leave status, which is decided at the weekly multidisciplinary team meeting and which enables them to leave the ward either accompanied by nursing staff or unaccompanied.

On the day of inspection, the door to the unit was locked. It was reported that the door is usually locked although there is a new open door policy which has been distributed to the staff. There was no CCTV within use within the unit although the main door is linked up to a camera. The only other use for the ward is for a clozapine clinic which is facilitated in the clinic room. It was reported that this does not impede on the routine of the ward.

There are five nursing staff on duty during the day and three at night. The staff are allocated via a central roster. It was reported by the staff team that it has been very frustrating and is contributing to low morale within the unit. There are two household staff on duty on the unit. There is no formal induction for staff to the unit. The female staff wear a uniform, the male staff are casually dressed. There is no ward clerk and it was reported that this would be beneficial to the unit. The duty doctor is contacted to take blood as required.

It was reported that six people currently on the ward could be transferred to other facilities if these were available in the community. It was further reported that two female patients were progressing well within one of the supported residences in Dundalk as part of a pilot scheme, spending periods of time on long leave at the hostel. At the end of the pilot scheme, which ran for three months, the extra nurse was withdrawn from the residence and therefore the two residents have had to return permanently to the acute ward. Although it was recognised by all concerned that their leave was progressing well, these two patients have been denied the opportunity of continuing their trial leave process within the supported residence. Both patients were interviewed on this inspection. Both were very distressed by this decision and feel it is unfair.

Maintenance is carried out by staff from within the hospital. There was a central switchboard during working hours; outside working hours this unit provides the switchboard for the rest of the hospital. This means that all calls going out and in to the hospital are through this busy ward. Household staff are provided by the HSE.

Visiting times on the unit are fixed between 1400h and 1630h, and between 1900h and 2100h. Meal times are at set intervals and there was free availability of snacks and drinks throughout the day.

SERVICE USER INVOLVEMENT

The general feeling was that if the patient wants information about their treatment and therapies they have to request it. There were some information leaflets on the display board in the ward. Most of them pertain to health promotion. There is a complaints policy in place but there are no leaflets to advertise this fact. Patients' views about the unit are obtained through one-to-ones with their key worker and through the weekly community meeting. Carer and family opinions are sought through phone calls and when they visit the unit. There is access to advocacy and there is a suggestion box within the unit.

RECORDS

The medical files contain the patient's name and ID number. They were legible and reasonably tidy. The entry gave the name and, in most cases, the title of the personnel. They were all signed and dated. There were no progress reports from allied health professionals. One of the social workers on the unit

explained that he keeps his own set of notes. There is a treatment plan contained in the medical notes and there are progress reports which are signed and dated. The consultant psychiatrist reviews patients at least weekly and in some cases twice a week and the NCHD is available on a daily basis.

The nursing files contain the patient's name and ID number on all pages. They are legible and tidy and the entries have full names and titles of personnel. Entries are signed and dated.

Medication charts are all up to date and recently rewritten. The system in place in the hospital ensures that all medication cards are rewritten every three months.

The charts of a person who had been either secluded, restrained or detained under the Mental Treatment Act (1945) were reviewed. All of these charts were appropriate and gave the necessary details and information.

ENVIRONMENT

This was a 30-bed acute admission ward in a psychiatric hospital. There was a regular maintenance programme and there was disabled access throughout the unit. Generally the lighting, ventilation and décor were good and the noise levels were appropriate within the unit. There was an information board with some up-to-date information. A code of conduct was visible, being displayed within the unit.

There was a separate admission area adjacent to the ward which had a waiting area and an interview room. The interview room had a phone link and there was a second exit from this room.

The bedroom area had two large dormitories, one for male patients and one for female patients. There was one single room in the female dormitory. Each of the bed areas had curtains around them that were collapsible and there was individual wardrobe space. There were 16 male patients in the dormitory and 13 in the female dormitory.

The toilets and bathrooms were of a reasonable standard. There was free access to toilets and showers but not to the bathrooms. There was a policy in place following an attempted suicide that the bathrooms are locked and anyone wishing to have a bath is supervised. The toilet areas were gender specific and all the doors had overriding locks.

The dining area had space for all patients at one sitting and was situated centrally within the unit. The lounge area was fairly large and had a TV and some comfortable seats.

There were three interview rooms within the unit, one in the main corridor and one at the end of each dormitory. The rooms at the end of the dormitories were fairly remote and it was explained that a patient at risk could not be interviewed in any of these rooms. The nurses' station was situated centrally within the unit. It was of a reasonable size, there was space for report writing and it was accessible and confidential. There was a telephone and IT system in place and there was an alarm system which needs updating.

The clinical room was situated off the main corridor of the ward. The procedures carried out in the clinical room included taking of bloods and the medication round. A clozapine clinic was conducted there. There was the appropriate medical equipment, which is checked on a daily basis.

The ECT suite was off the main corridor of the ward. There was all the appropriate equipment.

There was a dedicated area for the staff which consisted of a changing room, rest room, toilet and showers.

There was adequate storage for patients' possessions on the unit. The patients' money system was through the general office and the hospital shop had a system of credit. There was adequate storage for files and records, medication and catering and linen.

The seclusion room was situated centrally within the main body of the ward and opposite the nursing station. The walls were clear and the windows contained reinforced glass. The door had an observation panel, it was wide and it appeared to be solid. Within the room was a soft bed of adequate height. The décor, lighting and ventilation were all satisfactory. There was a seclusion policy and a seclusion register which stipulated the date and time of initiation. The reason for seclusion was signed by the appropriate people.

STAFF TRAINING

There is training available for the staff on the unit. However it was pointed out that if staff wanted to undertake a degree or diploma course they may have to find a course to do in their own time although they may be supported financially.

OUR LADY'S HOSPITAL, NAVAN

DEPARTMENT OF PSYCHIATRY

Date of inspection: *20th July 2005*

Number of beds: *26 integrated*

DESCRIPTION

This is an open acute unit on the ground floor of Our Lady's Hospital. Since last year four of the beds have been designated as beds for the Psychiatry of Later Life (POLL). These beds were all vacant at the time of inspection. The observation suite is part of the bed complement. In line with the Royal College of Psychiatrists' recommendations and previous inspections there are plans underway to redevelop the doctor's office and the observation suite. There are also plans to modify the existing ECT suite.

In November 2003, a home-based treatment team was established and this has significantly reduced the rate of admission to the acute unit in the hospital, so there are regularly vacancies on this unit. Access to the home-based community treatment teams is through the sector team. The criteria for patients to be managed by the home-based treatment team is that they are suitable for admission. This 9-to-5 service operates seven days a week and involves five nursing members.

REFERRAL

Patients may be referred by any member of the multidisciplinary team and the GP, An Garda Síochána, or the courts. Patients who refer themselves are usually referred first back to the clinic. The decision to admit is usually made by the admitting doctor. The Inspectorate was informed that negotiations were underway regarding the assessment of patients in the A&E department.

Temporary patients are generally brought directly to the unit. All the sectors provide a liaison service to the rest of the hospital. There is a detailed admission policy. No patients under the age of 16 were admitted in the last year. One patient in the unit has moderate intellectual disability and has been an in-patient for more than two years under the care of the psychiatric team for the sector. Learning disability services are involved. Patients are not admitted for detoxification. Patients with substance dependence need to be medically stabilised first. Admissions for social crisis do not usually occur. There are two respite beds in the Rath na Ríogh Hostel which may be used for this purpose. The acute unit provides care for mothers and babies, in which case the baby is managed in a single room and is considered to be a patient of the service. There is a policy in relation to this.

Following assessment regarding the appropriateness of admission, the sector team doctor performs the psychiatric assessment and physical examination. Collateral history is taken when available. The person making the decision to admit is usually the NCHD. If there are any issues the matter is raised with the NCHD or consultant. The GP is generally contacted if a collateral history is required. The GP is notified regarding discharge via a discharge summary.

PROCESS OF ADMISSION

After an admission to the unit, the key nurse performs a nursing admission checklist. The patient is involved in formulating his or her initial treatment plan if able and signs the care plan. All patients are reviewed by the consultant within 24 hours if they have been certified. The policy regarding nursing in night clothes appears to be inconsistent and depends on the sector team. Some patients attend day centres or programmes during the day and are required to change back into their night clothes on return to the ward. Patients have complained that the use of night clothes may be regarded as either a privilege or a negative sanction. There is no written policy on observation levels. There is a policy on one-to-one nursing observation only. There is however a regular patient checklist carried out on the unit at set times throughout the day. The key worker is assigned on the basis of sector teams.

Cavan/Monaghan, Louth/Meath

CARE PLAN

There is no initial multidisciplinary assessment. Patients are referred when appropriate to the psychologist and social worker. There is no occupational therapist in the service. Most of the sector consultants conduct weekly review meetings on the unit. Nursing staff reported that some teams don't formally review on the unit and conduct these reviews instead at the outpatient clinic. Subsequent information received contradicted this assertion. There is a discharge checklist which is completed on all patients. There can be a delay between the discharge of patient and discharge summaries being sent out. This particularly occurs at times of changeover in medical staff.

NURSING PROCESS

An adapted form of the Roper Logan and Tierney model is in use which requires the patient to sit with the nurse and sign the nursing care plan. This model has been adapted as it is considered to be useful for people with learning disability and elderly patients. The nursing care plan is reviewed at least on a weekly basis, if not daily. The patient is involved in the review. As yet there is no formal risk assessment in this care plan. There were plans for the clinical practice coordinator, the Assistant Director of Nursing and unit manager to audit this new model soon after inspection. Currently the home-based treatment team is using a risk assessment as part of its assessment package, based on the Sainsbury Model, and there were plans to introduce this into the nursing care plan in the acute unit. All nursing staff wear a name badge.

ACCESS TO THERAPY

The psychologists run discussion groups on the unit. Patients can be referred to a psychologist or a social worker by the consultant when considered appropriate. There is no access to an occupational therapist. Patients may be referred to the family therapist, behaviour therapist or addiction counsellor, although this usually occurs following discharge. The consultant psychiatrists review their patients regularly and frequently. Access to medical and surgical services is good. The unit has recently been brought online and can receive laboratory and X-ray results in this manner along with the rest of the hospital.

ACCESS TO THERAPEUTIC PROGRAMMES

An activation nurse has been appointed since March of this year who runs a programme five days a week from 0900h to 1700h. This programme is not fixed in that it is individualised and adapted depending on patient need and includes arts and crafts, relaxation, solution to wellness and a men's group.

ECT

The Royal College of Psychiatrists have made recommendations which are in the process of being implemented. It is now suggested that the waiting area should be in the activities room given that there would be no programme taking place at that time. The ECT room doubles as the clinical room and there is a recovery room with three beds. There are now plans to locate the monitor, cardio-pulmonary resuscitation equipment and defibrillator in the new treatment room. The inspector was informed that the Royal College of Psychiatrists' recommendations are required to be implemented by October 2005. There is an ECT policy and procedure with a register, consent form and appropriate checklists. There is no designated ECT nurse. There is a designated ECT consultant.

SECLUSION

Seclusion is used in this unit and there is a policy in relation to this along with a register and the appropriate documentation. The seclusion room is part of the observation suite which is currently undergoing modification. Currently it is not satisfactory. It is a large room which cannot be properly ventilated. The windows cannot be opened and it is not soundproof. It is well lit but there are no curtains on the window. There is a toilet area just off the room. There is another single room alongside it. Refractory clothing is not used in this unit. There was no CCTV in use in the unit although its use was being considered.

CLINICAL RISK MANAGEMENT

There is a policy on risk management which involves a new report form on incident, near miss, hazard and complaints. These forms are sent to the corporate risk management group who audit and follow up serious incidents. There is an alarm system in operation in the unit. There is a policy on missing persons available. There is a policy on the use of physical restraint and it includes the management of violent episodes. There is no policy in rapid tranquillisation. There is a policy and procedure on giving medication without consent which is part of the medication management policy. There is also a policy on mechanical restraint although it is not used. Staff are all trained in the professional management of aggression and violence (PMAV) which has a strong emphasis on prevention. Staff also receive training in basic life support and receive regular updates on medication. Support and debriefing is provided. Formal clinical review is conducted following serious incidents in accordance with the tracking system already mentioned.

UNIT MANAGEMENT

There are no temporary transfers to other units. Occasionally patients may be admitted from St. Brigid's Hospital in Ardee if it is full there. Generally it is recommended that a more settled patient nearing discharge be transferred rather than an acute admission. These patients are looked after by the consultants from St. Brigid's, Ardee. Patients can be discharged to St. Ita's Ward or Our Lady's Ward in St. Brigid's Hospital (both long-stay units). A clozapine clinic is conducted once a week on the unit. Patients are allowed off the unit following discussion at the review meeting. They are encouraged to notify staff. There is a policy on locking the door which has been prepared but still needs to be signed off. The nurse in charge makes the decision and patients are notified that the door is about to be locked and a form is sent to the Director of Nursing stating the reason and duration. The ward is locked each night from 2100h onward. For the confused elderly a tagging system is used whereby as the patient nears the door of the unit it locks automatically.

There are five nursing staff on during the day along with a unit manager and there is a clinical nurse manager and two nursing staff on by night. Unit rostering applies.

There are two full-time household staff on day duty along with an attendant. Contract cleaners also come in for two hours a day. There are concerns about the use of contract cleaners given the lack of Garda clearance, their understanding regarding privacy and confidentiality, and the fact that they don't wear identification badges. An induction package is used for the induction of nursing and medical staff. With regard to dress code, female staff wear a uniform. There is no formal dress code regarding the male staff. There are four administrative staff for the unit who attend to filing, the switchboard and patients' finances. A designated clozapine nurse attends the ward on a twice weekly basis and takes the relevant bloods. Phlebotomy is not available from the general hospital. The NCHD performs phlebotomy.

There is no waiting list. Currently on the unit there are three patients waiting appropriate discharge placement. Staff are not satisfied with a level of support from maintenance. The general hospital provides assistance for minor matters. However there is no ongoing programme of maintenance and for larger projects it is unclear as to who provides the service.

Visiting times are flexible however patients are discouraged from having visitors during programme times. There are vending machines with drinks and snacks available on the ward. Meal times are at 0900h, 1230h to 1330h and at 1700h with snacks at 1030h, 1500h and 2100h.

SERVICE USER INVOLVEMENT

Beside the nursing station and in the reception area there is a notice board with leaflets and information on patients' rights, key nurse and the activity programme. There is a hostel-wide complaints policy and details of this are in the information leaflet. There are weekly community meetings with all the patients. The advocate attends these weekly meetings. There are two public phones but patients complain about the costs involved in using these.

Cavan/Monaghan, Louth/Meath

RECORDS

Medical records were satisfactory although there is no signature bank available. In general, entries had the full name and title of the person making the entry and entries were signed and dated. Where patients have been seen by a psychologist or social worker this was generally written into the clinical file as part of the continuation sheets. There was evidence of regular consultant psychiatrist and NCHD review in the files perused. The nursing history and assessment care plans were completed and satisfactorily maintained. Progress notes were entered twice daily. There was a signature bank available. Entries did not always have the full name or the title of the person. Medication, prescription and administration records were satisfactory in general. The seclusion register was dated, the time of initiation and the reason for seclusion were noted. It was not routinely signed by the consultant psychiatrist. The nursing staff had a 15-minute checklist and also a seclusion care plan which was completed on the patient checked.

ENVIRONMENT

There is a reception area leading into the unit which looks on to a central garden area. The biggest environmental difficulty faced by this unit was the lack of an ongoing maintenance programme. Thus the garden area was overgrown, rendering it difficult to walk down some of the paths. There was no sheltered outdoor smoking area. There was no internal sheltered smoking area. The outdoor area was littered with cigarette butts.

There was no disabled shower in the unit. There was one bath. One of the showers had not been working for the previous six weeks. It had been leaking through and there was evidence of rising damp and water damage to the adjacent areas. The lighting and ventilation were satisfactory. The décor was sparse. The corridors were wide. There was a clearly defined reception area with a receptionist, information boards, brochures etc. There was a comfortable waiting area with comfortable seating. The doors were open. Currently there is one room for the junior doctors which is shared by them all and is used occasionally as an interview room. Three of the consultant psychiatrists have offices on the unit and one of these allows the office to be used for interviews and study. The nursing office also doubles as an interview office. There were two 6-bed rooms, two 5-bed rooms and four single rooms, all en-suite. One of the male rooms has no ventilation. There are curtains around the bed areas and individual wardrobe area. The bathrooms and toilets were sparsely décorated. They were gender specific. There were no overriding locks. The dining room was satisfactory. There was space for all patients at one seating. It was self-service and integrated. However the pool table, exercise tables and table tennis tables were all contained in this room along with the seating area for the TV. There was no separate exercise or activity area. There was one activity room adjacent to the ECT suite and this is used as the waiting area for the ECT room. There was one non-smoking lounge area with some comfortable seating although more was required. One newspaper is delivered to the ward every day. There was TV, video and radio, books and notices inviting donation of books etc. There is an alarm system in use in the ward. The nursing station is centrally located and reasonably confidential. There isn't adequate space for report writing. There are telephones and a computer available.

The clinical room which doubles up as the ECT treatment room did not have an examination couch currently although following the modifications this will be provided. There was a defibrillator available. The Spectron 5000 machine is the ECT machine used. In the staff area there are changing rooms, rest room, toilet and showers. The showers again need to be made more private. There is a library in the hospital which can be used by the staff in the unit and there is no study room in the unit itself. When mothers and babies are admitted the baby is admitted to the single room and given special observation. The mother may be admitted to the dormitory or single room depending on clinical need. All the single rooms are minimally furnished. There was no designated visitor area thus either the sitting room or outside the unit is used instead.

The seclusion room was called the observation room and was used both as a bedroom and a seclusion room. It was located beside the nurse's station and was not soundproofed. The windows did not open and there were no curtains. There were soft furnishings; the décor was very bare, the ceilings were high and there was no ventilation. There was

an observation panel in the door which was solid and of inadequate width.

STAFF TRAINING

There is training available for all staff from the HSE Area training unit and staff are very proud of their development and training in the professional management of aggression and violence. The unit has received a Q mark over the last number of years.

LOUTH/MEATH

AN SOLASÁN

Date of inspection: *20th July 2005*

Number of beds: *16 integrated*

DESCRIPTION

An Solasán residence is a 16-bed community residence with 24-hour nursing staff supervision, with one respite bed. The residence opened in 2002 and is situated close to town. There were five male residents and ten female residents on the day of inspection.

REFERRAL

The sources of referral to this residence are St. Brigid's Hospital in Ardee, other residences in the area and the community. A consultant psychiatrist contacts the residence and a referral form is completed. An assessment then takes place. The residence provides a service for the elderly population. There is a gradual process of transfer to the residence.

PROCESS OF ADMISSION

There is an admission policy in existence and the general emphasis is on a gradual process of familiarisation with the residence. The reason for admission is for continuing care for elderly patients. There are respite beds within the residence and currently there is a resident on long-term respite. There is no immediate assessment made on admission due to the fact that information is gathered on an ongoing basis through the transfer process. Physical well-being is maintained by a GP and all residents are registered with a local GP. It is a team decision to admit a resident to the residence. There is communication with the residents and also their families. The consultant psychiatrist is available to review the residents on a weekly basis. The initial treatment plan is documented in the notes and there is a key worker system in place.

CARE PLAN

Care plans in the residence are predominantly nurse led. Needs are identified and are based around the multidisciplinary team meetings. There are goals and objectives identified and there is a key worker responsible for ensuring the care plans are reviewed.

NURSING PROCESS

The residence uses the Roper Logan Tierney model which has been adapted to suit their needs. The implementation is by the key worker and there are some aspects of a risk assessment contained within the Roper Logan Tierney model. It was pointed out to the Inspectorate that there is a planning process for a Louth/Meath Risk Assessment Policy.

REHABILITATION TEAM

There is no access to a rehabilitation team in this area. There is no clinical psychologist available. There was access to occupational therapists, via a GP, for seating assessments and there is access to a social worker and other counsellors. There are two consultant psychiatrists who have admitting rights to the residence and they are accessible weekly. Each resident is registered with a local GP and there is a good rapport between the GP practices and the residence. There is also access to a chiropodist.

INVOLVEMENT IN REHABILITATION PROGRAMMES

There are some programmes facilitated on the unit, mainly activities that are run by the nursing staff for the residents.

Cavan/Monaghan, Louth/Meath

CLINICAL RISK MANAGEMENT

There is evidence of policies on clinical risk management available. Any serious untoward incidents are recorded on appropriate forms and there is feedback given regarding the forms.

UNIT MANAGEMENT

There are no temporary or long-term transfers from the residence to accommodate bed shortages elsewhere. The skill mix within the residence is all qualified staff. There are three staff on duty during the day consisting of one CNM1 and two staff nurses and at night there are two staff, one CNM1 and a staff nurse. There is also a CNM2 available from Monday to Friday 0900h to 1700h. The staff are rostered on a permanent basis to the unit. There is one member of household staff on duty from 0800h to 2000h and one from 0900h to 1700h

The ethos of the residence is to provide continuing care to an elderly population. It has however been pointed out to the Inspectorate that a number of the needs for this elderly resident group are difficult to meet within this residence. The main example is if somebody has severe dementia or if their physical needs cannot be met.

HOUSE RULES

Due to the nature of this resident group there are very few house rules to be adhered to. There are designated smoking areas. There are flexible visiting times but people are asked not to visit too late at night. Some residents can leave the residence unsupervised but it is not safe for others to do so and therefore they are accompanied.

The main meal of the day is prepared in the hospital adjacent to the residence. Residents are involved to a certain extent in menu planning and have recently met with the catering manager from the hospital to discuss their dietary needs. At the moment residents are not allowed access to the kitchen. This is due to a number of reasons but predominantly health and safety. The kitchen is of an industrial type and it is deemed inappropriate for residents to have free access to these facilities. Therefore drinks and snacks are provided on a regular basis.

Residents are not required to go to bed or get up at certain times although people are encouraged to get up for their breakfast which is at 0900h All the residents have single rooms which are immaculate in presentation.

The majority of the residents do not manage their own finances. There is a policy on the financial arrangements within the residence. All residents have a post office savings account and there is a system of their pensions being paid from this post office. Staff collect the pensions on a weekly basis and the residents have free access to their money during the week. Residents buy their own clothes in the local shops. There is supervised access to the utility room as some are not capable of doing their own washing and it has to be done for them.

SERVICE USER INVOLVEMENT

There is information on treatment and therapies available. All residents are eligible to vote. There is a HSE Area-wide complaints policy which is advertised within the residence. The staff meet with the residents on a daily basis to plan the day and whatever activities the residents want to participate in. There is also access to advocacy services.

RECORDS

The medical notes contain patient details. The resident name and number is on each of the pages and they are reasonably tidy. There is, however, minimal information written about the residents. There are periodic reviews and interventions where the nursing staff have requested a doctor to review a resident. The nursing files are legible and up to date. They contain up-to-date care plans which are regularly reviewed.

The medication system is the same as the rest of the hostels and hospital in the area. The system enforces the writing of new prescriptions every three months. There are no residents on a self-medication programme at the moment although there is a policy available.

ENVIRONMENT

There was a regular ongoing maintenance programme in place which was carried out by the Louth County Hospital. The residence was immaculate. The décor was excellent. The furniture provided was an excellent standard and all residents had single rooms that had a sink. It was a safe environment, with all on the ground floor. The residence consisted of single bedrooms, a smoking lounge, a non-smoking lounge, dining room, kitchen and sufficient toilets and showers although there were some issues about a bathroom that required alteration. There was also a lovely garden area which was enclosed and contained a patio area.

STAFF TRAINING

There are a number of courses available through the regional educational centre. There is funding support available and staff are encouraged to take courses.

The service is planning to introduce an open door policy, a policy that will cater for patients who wander and also the instigation of a health promotion residential care initiative/self appraisal questionnaire in September.

DE LA SALLE HOUSE, ARDEE

Date of inspection: *19th July 2005*

Number of beds: *16 integrated*

DESCRIPTION

De La Salle House was opened as a high support residence in 1973. The house is a former monastery and is leased by the HSE from the local parish council. Parts of the grounds are accessible to the residents but the remainder is overgrown and is not included in the lease. Twenty-four-hour care is provided to the residents who have severe and enduring mental illness. There is no rehabilitation team and three consultant psychiatrist led sector teams have admitting rights to the residence. The residence functions as a long-term home to many of the residents and as a short-stay rehabilitation residence for others. The age range of the residents is from 30 to 80 years.

REFERRAL

At present there is no formal admission policy but there is one currently being prepared for all the community residences in the Louth/Meath catchment. Residents are usually referred from the acute unit. Following a letter from the consultant psychiatrist, one of the residence staff visits the unit and meets with the individual and their family or carer and reviews the clinical file of the prospective resident.

PROCESS OF ADMISSION

Staff in the residence have produced detailed criteria regarding suitability for residence placement and criteria that may exclude an individual. The history and current circumstances are then discussed with the consultant psychiatrist before a decision to admit is made. Although there is no designated respite bed, people are occasionally admitted for respite or because of social crises. Following admission a full psychiatric and physical examination and a nursing assessment is carried out. A key worker is then appointed. The resident is reviewed by the consultant psychiatrist or an NCHD when necessary.

CARE PLAN

Each resident has a nursing care plan with identified needs and agreed goals, which is evaluated every two months. It is about two years since a resident was discharged from the residence. There was one resident who was waiting for suitable accommodation with a lower level of support at the time of inspection.

NURSING PROCESS

The Roper Logan Tierney model was in use, but the staff have adapted this to suit the residents' needs. It contains a risk assessment. The nursing staff do not wear identification badges as they are well known to residents.

REHABILITATION TEAM

There is no rehabilitation team in this catchment area. A consultant psychiatrist reviews residents every

three to six months but an NCHD reviews residents every six weeks. Residents have a choice of two GPs to register with, and four of the residents access the GP by themselves. The other residents are accompanied by staff.

INVOLVEMENT IN REHABILITATION PROGRAMMES

Five of the residents attend their sector day centre in Drogheda. Four attend Ardee day centre. Some of the residents are retired. Others choose not to attend services off site. At the day centres, the residents are engaged in contract work for which a small allowance is paid. This money is pooled and used for communal activities such as outings. Some activities such as arts and crafts and singing take place in the residence.

UNIT MANAGEMENT

There are no temporary transfers to or from other units. The residence is not used for any other purpose. There is central rostering to the residence. The CNM2s who work opposite each other provide continuity but other staff are rotated. Two nurses and one household staff are on duty during the day and one nurse on duty at night. Each year a written profile of the residence is updated and this serves as an aid to staff and resident induction. The HSE is responsible for the maintenance of the residence and maintenance staff from St. Brigid's Hospital provide a good service but, because the residence is not owned by the HSE, no major upgrade of the residence has taken place since its opening. Staff use personal alarms. A response is organised from Unit 1 in St. Brigid's hospital. At night the nurse on duty has access to a hands-free phone. There have been some problems with the security of the residence, which is easily accessible from the road and through the parish property.

ETHOS

The ethos of the residence is to provide a homely atmosphere with emphasis on quality of life by developing the potential of each resident and maximising their potential and independence. Residents are supported in participating fully in the local community.

HOUSE RULES

The rules of the residence are designed by the staff in conjunction with residents. They are reviewed when necessary. Visiting times are flexible. Most of the residents are allowed leave the residence unaccompanied but all are required to check in and out with staff. A register of patients is taken at 1930h for safety reasons and to provide information for the staff on night duty. Household staff prepare breakfast and evening meals with the lunch coming from the main hospital. Residents are encouraged to be involved in planning and preparing the breakfast and tea menus and meals. Residents have free access to the kitchen to make drinks or snacks. There is a designated smoking room and no smoking is allowed in bedrooms. Residents are not required to go to bed or get up at set times.

There is no policy on the financial management of residents' money. Several residents manage their own money completely. The money of some residents is collected by staff. All of the residents have bank accounts. Some of the residents buy their own clothes unaccompanied while others are accompanied by staff. Several of the residents do their own laundry. The remainder have theirs done by the housekeeper. Several of the residents access community services unaccompanied, such as GP, mass, shops and pubs. The residence is within easy walking distance from the town, where there is public transport available.

SERVICE USER INVOLVEMENT

Each year the residents are asked to complete a satisfaction questionnaire. The results are collated by staff who do not work in the residence, and they give the feedback in order to preserve the anonymity of the residents. Residents are given verbal information on diet, medication and therapies and they have access to the annual profile of the residence, which outlines the charter of patients' rights. There are information leaflets available on outside agencies and services and residents are given verbal information on the complaints procedure.

Informal community meetings are held from time to time. There is no access to an advocacy service.

RECORDS

The residents' charts were neat and manageable. They contain dated and signed progress reports from nursing staff. They also contain care plans, but no entries from professionals other than doctors and nurses. The full name and title was not always used but a signature bank is available. There is a daily record of issues that arise and a weekly summary is documented. Residents can access their files.

There is no policy of encouraging those who can to self-medicate and none of the current residents self-medicate except when they are on leave. A policy is currently being prepared. Prescription and administration sheets were signed, dated and legible.

ENVIRONMENT

The residence was in need of upgrading. The décor was poor but the furnishings were comfortable. The layout of the residence was not suitable for residents who may be frail or have mobility problems. The ground floor consisted of a kitchen, open utility area, dining room, a smoking lounge and a non-smoking lounge, a multipurpose room, residents' toilet, shower room, staff toilet and two bedrooms. The first floor had one bathroom, two toilets, a fire exit room, an office and nine bedrooms. There was a shortage of personal storage places for residents. There was no private area for residents to sit outside the house.

STAFF TRAINING

There is a nurse training programme available and staff feel that they are facilitated in accessing relevant training and courses.

RATH NA RÍOGH, NAVAN

Date of inspection: *20th July 2005*

Number of beds: *12 integrated (2 respite, 10 other)*

DESCRIPTION

Rath na Ríogh is a 12-bed high support residence which opened in 1997. It is a two-storey house located in the town of Navan. The residence caters for individuals who suffer from enduring mental health problems while offering two respite beds for the catchment area of County Meath. Supervised care 24 hours a day enables residents to maximise their potential and improve their quality of life with the involvement of families within the community setting. The function of Rath na Ríogh is to provide 24 hour supervised care and rehabilitation for people with continuing mental health problems who are unable to live independently in the community. The overall aim is to identify needs, promoting independence and self-esteem while encouraging personal choice in decision-making. The service aims to affirm and enhance dignity, self-respect and individuality, freedom of choice, maximising levels of independence and encouraging individual expression and self-awareness. The service also aims to encourage residents to integrate into the community with the involvement of local services and voluntary services. There are plans to develop an assertive home outreach programme. Currently the patients there are under the care of the consultant psychiatrist for the Navan sector. The respite beds as stated are for the entire county and are managed by the respective team. The age range is from 30 to 82 years.

REFERRAL

The two respite beds are managed by the nursing staff and are available for patients from the three sectors in County Meath. The source of referral is usually the community nurse, day centre or sector team. In the first six months of 2005, 23 patients had presented for respite, 22 of whom were discharged.

Cavan/Monaghan, Louth/Meath

PROCESS OF ADMISSION

If patients are new to the service they are invited to visit the residence prior to respite admission. There was a very slow turnover for the long stay beds with an admission occurring every two years. The admission policy is that patients have to have failed in every other community support prior to admission to a long-stay bed, thus they would be well known to the service prior to acceptance into the residence.

CARE PLAN

Care plans in the residence are predominantly nurse led. A multidisciplinary assessment is conducted on a needs basis. There were no long-stay residents discharged in the last year.

NURSING PROCESS

The residence uses the Roper Logan Tierney model which the staff have adapted to suit their needs. There is a key worker system and staff wear name badges. All long-stay residents are registered with a GP which they are able to access themselves, sometimes with assistance. The staff are satisfied with the level of psychiatric cover provided by the consultant psychiatrist.

REHABILITATION TEAM

There is no designated rehabilitation team in the service.

INVOLVEMENT IN REHABILITATION PROGRAMMES

The majority of the patients attend the day centre daily. Residents are involved in cleaning, laundry, gardening etc. All of the residents attend day services off site apart from two. One staff member attends the day centre with the residents. The day centre is in close proximity to the residence.

CLINICAL RISK MANAGEMENT

The auditing of serious incidents procedure was the same as that in the acute unit.

Staff training was conducted at the regional training centre in Ardee. Staff were encouraged to attend and the member of staff interviewed had taken management courses, computer courses and preceptorship training.

UNIT MANAGEMENT

There are no temporary transfers or long-term transfers from other units. The residence is not used for any other purposes. There are two nursing staff on duty by day and one at night. Many of the staff working in the unit have been there for a long period whilst the staff member interviewed had been in the unit since its opening in 1997. There is one housekeeper from 0900h to 1700h and a cleaner comes in for a half day twice a week. An annual report in relation to the statistics is compiled. There is a formal process of induction for residents and staff and there are policies and procedures present. There is an informal or casual dress code. In 2001 a quality of life survey was conducted. This basically showed that patients appreciated the residence. The unit obtained the Q Mark in 2004. At the time of inspection, there was one patient in the acute ward who was considered to be appropriate for the residence but there was no vacancy for her. In common with other hostels there was some dissatisfaction expressed at the level of maintenance support as this was located in St. Brigid's Hospital, Ardee and was somewhat difficult to access.

HOUSE RULES

House rules were designed when the unit opened and these were reviewed at the monthly residents meeting. Visiting times are flexible. Residents do not have a front door key. Residents are able to lock the bathroom door, however this is considered to be a safety issue and staff are looking for overriding locks. Residents cannot lock their bedroom doors although staff will lock them for them if required. Residents are allowed to leave unsupervised., but are required to notify staff if they are coming in or out. The residents

are not required to be out during the day. There is a chef on the unit so all food is prepared on site. Residents are involved in meal planning and shopping and residents have free access to the kitchen to make drinks and snacks. Residents are not generally required to go to bed at set times. They are not allowed to smoke in their bedrooms. There is one double room; the remainder are single rooms which means that all residents can have a single room. Residents are not able to have visitors stay overnight. Those going to the day centre are called in the mornings. They have to be at the day centre by 1030h or 1100h. Residents' belongings are not listed or checked except in the case of those admitted for respite. As far as possible, residents manage their own finances. Prior to the inspection the charges had recommenced. Prior to November of last year residents had been charged €57 per week. Staff assist the patients in managing their money if required. One resident had a bank account. Most of them had their money in savings accounts. Residents are as far as is known in receipt of all benefits. Residents are not asked to pay for new furniture or fittings for the residence. Residents buy their own clothes in the local shops and have free access to the utility room. Residents can access the services in the community unaided depending on their ability, e.g. the shops, pub, day centre. The local services are within walking distance and there is access to the public transport service.

SERVICE USER INVOLVEMENT

There is a monthly meeting with the residents, of which minutes are kept. A computer has been acquired for the residence since 2002 however recently some data had been lost regarding the minutes. There is a regional complaints procedure which is documented on a leaflet that is freely available. Families, relatives and carers are encouraged to visit the unit and every year there is a barbecue where all are involved. The advocacy services attend the day centre and residents have access to it.

RECORDS

The medical case notes for respite patients are not kept in the residence, though the medical case notes for the long-stay residents are. Residents see the consultant psychiatrist in the day centre whenever requested. The senior registrar has a weekly meeting on the unit. The consultant psychiatrist attends on a regular monthly or so basis. Nursing files were satisfactory. The title was not always given in the nursing entries although the entries were identifiable as staff had worked there for some time. There was a signature bank available. Residents who were in respite beds or moving on to lower levels of support were on a self-medication programme. The card indexes were not always legible. They were otherwise satisfactory and generic names were usually used.

ENVIRONMENT

The residence was located close to the town centre of Navan with easy access to public facilities. Accommodation was a semi-detached house on two levels with three bedrooms on the ground floor and the remaining bedrooms on the upper floor. On the ground floor there were three single bedrooms with sink units and wardrobes. There was a large dining room-cum-lounge area off the kitchen. There was also a utility or laundry room and storage cupboard. There was a shower room with a toilet. However the shower rail was missing. A seat was missing off the toilet. There was a hallway, a telephone and a stairway to the upper floor. On the day of inspection, there were problems with the water in the town of Navan. On the upper floor there were seven single bedrooms with sink units and wardrobes and one twin bedroom with wardrobes. There was a non-smoking lounge room with comfortable furnishings. There was a bathroom with a sink unit and a toilet. There was a corridor with a hot press and storage cupboard where all notes and care plans were now kept. There was a staff office and staff toilet and shower. Staff allowed patients to use their shower. There was access to a large garden area which had a horticultural tunnel in it, which was not currently being used. There were seats outside the front of the unit for smokers. There was a paved area at the back and the side. There were plans to alter the layout at the back to facilitate parking for the building next door. The unit was pleasant and homely. Residents were encouraged with staff support to attend to their own personal laundry using the facilities provided in the residence. Bed and household linen were sent to the local HSE Area laundry facility.

Residents were expected to participate in general household cleaning duties, in particular their own bedrooms. The housekeeper had overall responsibility for maintaining a high standard of cleanliness throughout the residence.

ST. ANNE'S

Date of inspection: *18th July 2005*

Number of beds: *5 male*

DESCRIPTION

This is a two-storey house just outside the entrance to St. Brigid's Hospital in Ardee. Originally this house was used for disturbed adolescents and thus still contains a "control room" and has high fencing. It was adapted in particular to accommodate one resident on the closure of St. Dympna's Ward. This residence is seen as a home for life. There is a strong emphasis on rehabilitation and an unrestrictive lifestyle. Two sectors admit to this staffed residence. There is no rehabilitation team providing care to the residents in this service.

REFERRAL

Residents are referred by the sector team usually through the consultant psychiatrist. The consultant psychiatrist makes the decision to admit.

PROCESS OF ADMISSION

There was no specific admission policy in relation to the staffed residence. When a vacancy arises it is discussed at the team meeting. There are regular meetings involving the residence staff. Most residents are referred for rehabilitation. There are no admissions as an alternative to acute admission or for respite care. Most patients in this service attend the day hospital or occupational therapy. Usually some structure in the day is required or encouraged. There are no admissions for detoxification or for social crisis. There is a key worker system in place.

CARE PLAN

There is no multidisciplinary care plan of the five patients currently in the staffed residence. One patient is looking for a learning disability service. There are no residents awaiting accommodation in lower levels of support. All residents are registered with a GP and staff were satisfied with the level of communication with the GP. Some residents go out at weekends and some residents have visits home. The community teams attend the residence meetings and there are outings at weekends. Staff accompany the resident to the races, football, shopping every Saturday.

NURSING PROCESS

The nursing care plan in use is the Roper Logan Tierney model. This has recently been updated in that residents now sign their care plan. It is reviewed every month. It does not contain a risk assessment. There is a key worker system and staff do not wear formal identification.

REHABILITATION TEAM

This service is not under the care of the rehabilitation team but rather is under the care of the sector team. Residents can be referred to psychology, occupational therapy and social work. Counsellors are hospital-based as are the addiction counsellors and behavioural therapists. Staff in the hospital are very satisfied with the level of consultant psychiatrists' input and their availability. Consultant psychiatrists attend whenever requested and also do a monthly review of each resident. All the patients are registered with a GP. Some are able to access the GP by themselves.

INVOLVEMENT IN REHABILITATION PROGRAMMES

Two patients attend the day centre in Drogheda and are collected by the bus each morning. Two patients attend occupational therapy in St. Brigid's Hospital and make their own arrangements to get there. There are no plans to move the current residents on to a lower level of support. Residents attend day services off site and staff do not attend the day

services with patients. There is one particular resident who requires intensive input.

CLINICAL RISK MANAGEMENT

There was evidence of policies on clinical risk management. There were no individual clinical risk management assessments. Serious incidents are audited by reporting to the director of nursing. There is an alarm system in use within the residence with an arranged response. There are three separate phone lines. There is an emergency button on the phone.

UNIT MANAGEMENT

There are no temporary transfers from other units. The patients here came with the closure of St. Dympna's Ward. The residence is not used for any other purposes. In the residence there is a mixture of nursing staff and domestic staff. There are two nursing staff on by day and by night from a central roster. One domestic staff member is employed from 0800h to 2000h and tends to do all the cleaning and cooking. The ethos of the residence is that it is a place for life. There is a strong emphasis on rehabilitation. While an annual report is not compiled, a survey of the hostels has recently been conducted. There is no formal process of induction for residents and staff. The hospital policies apply to the residence and are not specific to the residence. There is no dress code.

Family and residents' level of satisfaction with the service is informally recorded through regular house meetings and conversations with families. There is no formal method of obtaining opinions. There is no waiting list and no residents were discharged to lower levels of support last year. The staff are very satisfied with availability of maintenance and household staff backup. House meetings are held once a month and minutes are kept.

HOUSE RULES

The rules relate to smoking, looking after the bedrooms and cleaning up after tea. Residents are required to inform the staff if leaving the unit and are required to be back before the night staff come in. Visiting times are flexible. Residents do not have a front door key. They are able to lock the bathroom door. They cannot lock their bedroom doors. Four of the five residents are allowed to leave unsupervised. Residents are not required to be out during the day. The domestic staff prepare the meals on site. Residents are involved in shopping with nursing staff for meals. Residents have free access to the kitchen to make drinks and snacks. Residents are not required to go to bed at set times. They are not allowed to smoke in their rooms. There is one double room and three single rooms. During the week, the residents are required to get up at about 0800h but there is no set time at weekends.

Residents' belongings are not listed. Residents do not manage their own finances. All the patients are on disability. The usual concern about the planned re-introduction of charges applied. Since the week prior to the inspection residents had again started paying €60 per week. Residents do not have access to their own money as required nor do they hold a bank card. Their money is managed by the hospital. Staff collect the money from the post office and €10 for the socialisation fund. As far as staff are aware, residents are in receipt of all benefits. Residents are not asked to pay for new furniture or fittings for the residence. Residents buy their own clothes in local shops and they have free use of the utility room. Residents access services such as the bookies, the pub, church in the community unaided. Local facilities are also in walking distance and there is access to the public transport service with the local bus station situated nearby.

SERVICE USER INVOLVEMENT

There are leaflets and videos available on clozapine and residents talk to the consultant psychiatrist or nurse about their treatment. The NCHD does not have regular input into the residence. There was some information available on national health initiatives. There was a complaints policy which had been updated in November 1998. There were no information leaflets on complaints. The monthly meeting is used to seek residents' opinions. The advocate visits.

RECORDS

If residents wish they can apply under Freedom of Information (FOI) legislation to see their chart. Residents do not write into their file but they can sign the nursing care plan. The resident's name and ID number was not on all of the pages. All the medical entries were legible and tidy. The files contained progress reports from other health professionals and a nursing care plan. Consultant psychiatrists appeared to review the notes on a regular basis. There was infrequent NCHD review. Nursing notes were satisfactory, apart from not having the full name and title of the personnel. Nursing entries were made twice a day and there was a review of the nursing care plan once a month. Residents were not on a self-medication programme. The medication records were satisfactory and as far as possible generic names were used.

ENVIRONMENT

There was a regular ongoing maintenance programme in place delivered by St. Brigid's Hospital. The house was clean and pleasantly décorated. There were plans to refurbish the bathroom upstairs and to replace the bath with a walk-in shower. It was comfortable and private and safe. The residence was locked at night. It was a two-storey building with one bedroom downstairs. Downstairs the double bedroom led to the utility room and the garden and fire escape. There was a lounge and sitting room and a dining room with a hatch into the kitchen. There was a nurses' office and a toilet downstairs with a wash-hand basin. Upstairs there was a "control room" which was not used by the residents but occasionally was used as an office for studying. There were three single bedrooms, one bathroom and toilet and a staff sitting room. There was a high perimeter fence around the rear garden. The garden itself was pleasantly cultivated.

STAFF TRAINING

Staff receive training in cardio-pulmonary resuscitation, crisis management, manual handling and de-escalation. There is a booklet available detailing training courses available. The regional education centre is located in the hospital next to the unit.

ST MARY'S RESIDENCE, DROGHEDA

Date of inspection: *19th July 2005*

Number of beds: *14 integrated*

DESCRIPTION

St. Mary's is a community residence with 24-hour nursing staff supervision situated close to the town. There is one respite bed and currently there are seven male residents and seven female residents.

REFERRAL

The source of referral to this residence is the day centre and the acute unit in St. Brigid's Hospital, Ardee. There is no formal process of referral to the residence although the staff interviewed informed the Inspectorate that they are working on a referral pro-forma. There is a respite referral form. The mechanism of assessment is the consultant psychiatrist and residence staff assess the individual referral at the source of referral i.e. the acute unit or day hospital. Family contact is encouraged throughout the process.

PROCESS OF ADMISSION

There is an operational policy in draft format which on inspection appears to be very detailed and contained objectives, principles and the philosophy of the residence. It also contains criteria for admission to the residence, and also exclusion criteria. The exclusion criteria include physical inability to manage stairs, being on a Temporary certificate, a recent history of violence, or being in an acute state of illness. The main reason for admission to the residence is to assist with independence and to equip people with skills to move on to a lower level of supported accommodation. However there is a large number of elderly residents in the residence. People are admitted for respite care but are known to the residence, attend the day services and are in contact with one of the community nurses. They usually stay for a weekend.

The referral process involves periods of time spent at the residence on leave to become familiar with the routine of the residence and also meet the staff and

other residents. As a result, on admission most of the information needed is already ascertained. On admission they register with one of the GPs in the area, who is responsible for their physical well-being. It was reported that the resident is involved fully throughout the referral process and has opportunities to discuss their concerns with the nursing staff. Communication with families is encouraged by the residence and it was reported that the residence staff write to each resident's next of kin every six months to inform them of the need to keep in contact and to promote a feeling of support for the resident's family. The initial treatment plan is documented in the nursing notes. A key worker is allocated.

CARE PLAN

Care plans are based on the Roper Logan Tierney model and are predominantly nurse led. There is access to a social worker within the day centre. It was reported that the Roper Logan Tierney model is appropriate for the needs of the elderly residents but not the younger generation that are starting to use the residence. Care plans have goals and objectives identified and are reviewed routinely every three months. However, it was reported that if there is a new problem or an acute problem they are reviewed more often. Some of the residents sign their care plan and also the evaluation of the care plans.

It is unusual at present for somebody to be discharged from this residence.

REHABILITATION TEAM

There is access to a psychologist at St. Brigid's Hospital. There is no access to occupational therapy and a social worker is accessible in a day centre. It was also reported that there is access to an addiction counsellor in the community. Consultant psychiatrists are available as required by the residence staff but there are no regular reviews. It was also reported that there is a good relationship with the local GP practices. There are two nursing staff on duty during the day and one at night.

INVOLVEMENT IN REHABILITATION PROGRAMMES

The majority of the residents in the residence are elderly and attend the local day centre. Some of the younger residents attend training courses and FÁS courses.

CLINICAL RISK MANAGEMENT

There is evidence of policies on clinical risk management available as well as health and safety policies, procedures and checklists. There is some individual clinical risk management assessments contained in the nursing notes. Any serious incident is reported on appropriate forms and sent to management. It was reported that there is a risk assessment meeting held annually that gives some feedback on these incident forms and that nursing staff had attended this meeting.

UNIT MANAGEMENT

All staff within the residence are qualified and are regular staff. There is one member of household staff who overseas all the cooking, cleaning and laundry in the unit. There is no formal process of induction for new staff within the residence. The ethos of the residence is to promote as much independence as possible. There are appropriate policies and procedures present and there is a very detailed draft operational policy which needs to be ratified as soon as possible. The dress code is casual. Maintenance is carried out by St. Brigid's Hospital maintenance staff.

HOUSE RULES

There are some rules in place and these are displayed on the wall of the residence and they are designed by staff and residents and reviewed on an ongoing basis. Visiting times are flexible but people are encouraged not to visit too late. Most of the residents have a front door key although some have lost them. Bathroom doors can be locked and there is an overriding lock for the staff. The residents do not lock their bedrooms as a rule. Residents are allowed to leave the residence unsupervised, but they are asked to inform staff where they are going and what time they will be back.

Breakfast and evening meals are prepared in the residence, but the main meal is provided from St. Brigid's Hospital. Residents are not involved in meal planning or shopping. They have free access to the kitchen to make snacks and drinks.

Residents are not encouraged to go to bed at set times or to get up at any particular time. However it was pointed out that a number of them had activities to attend to and so therefore are prompted to get up at a particular time in the morning. Residents can have a choice in who they share a room with and if there is an option available could stay in a single room.

It was reported that 50% of the residents manage their own finances. Of those who do not, three people cannot collect their own pension due to physical disabilities so therefore the staff collect it for them and there is a signing procedure for this. Four other residents collect their own pension but give their money to the staff to look after, though they are encouraged to place the money in their savings accounts. A payment to the residence for rent and upkeep of €60 a week has recently been introduced. Residents buy their own clothes in the local area. There is free use of the utility room for laundry, but a number of the residents need support and the household staff do laundry for some of the older residents.

SERVICE USER INVOLVEMENT

Information is available on request regarding treatment and therapies and if there are any changes in their treatment the nursing staff explain this to the resident. There is a complaints policy in place which is the same as the one in St. Brigid's Hospital.

RECORDS

The medical files contain very little up-to-date information on the residents. There is a lot of historical information, but no up-to-date progress notes. Nursing files contain up-to-date care plans and the plans are regularly reviewed.

Medication charts are all up to date and clearly signed and are the same system as in St. Brigid's Hospital. The maximum duration a prescription card is available for is three months. None of the patients are on a self-medication programme.

ENVIRONMENT

There was a regular ongoing maintenance in place provided by St. Brigid's Hospital. General hygiene and décor of the residence was good and there was nice furniture available for the residents. It appeared to be a safe and appropriate environment. Although there were three bedrooms downstairs, due to physical difficulties and age a number of the residents may not be able to access the upstairs of the building in the future. On the ground floor, there was a dining room, kitchen, utility room, smoking room, three single bedrooms, two toilets with a bath, a sitting room and a ward off the unit office. On the first floor there were seven single bedrooms and three double bedrooms. There was a shower room and a bathroom.

STAFF TRAINING

There is full mandatory training appropriate to the residence provided as well as a teaching assessing course for mentoring student nurses. There is a regional training centre but it was reported that the majority of the courses are not geared towards mental health professionals.

THE MOORINGS

Date of inspection: *20th July 2005*

Number of beds: *15 integrated*

DESCRIPTION

The Moorings is a community residence with 24-hour nursing staff supervision situated close to the town. There are two respite beds and currently there are six male residents and six female residents.

REFERRAL

The sources of referral to the residence are the acute wards, long-stay wards and the community. A referral

form is completed and the referral is discussed by the team and an assessment takes place. It is common practice for all referrals to attend the day centre where staff from the residence work.

PROCESS OF ADMISSION

There is a gradual process of admission once a resident has been accepted. It is usual for the resident to visit frequently and spend time on leave at the residence to assist with familiarising themselves with the staff, other residents and the routines and rules of the residence. The only exclusion criterion is illegal drug use. The main reason for admission is to promote independent living and to integrate people back into the community. There are also admissions for respite care.

The assessment process is ongoing through a gradual familiarisation process. All residents are registered with a local GP and physical needs are managed by the GP. The decision to admit a resident to the residence is made by the team. Family members are also encouraged to keep in contact and it is noted that the majority of residents go home at the weekend and have good links to their family. The consultant psychiatrist is available on a weekly basis in the Ladywell Centre which is close to the residence. The initial treatment plan is documented in the nursing notes. There is a key worker system in place and each nurse has two residents allocated to them.

CARE PLAN

Care plans are nurse led with some involvement from a social worker and the staff at the day services. Care plans identify needs and highlight goals and objectives. Care plans are reviewed on a regular basis and the resident is encouraged to participate in the care planning process and is asked to sign the care plan to indicate they agree with it.

If a resident is being discharged a gradual plan is instigated. Last year three people were discharged to a lower level of support and there are currently four people who could manage in a lower level of support.

NURSING PROCESS

The nursing staff use an amended version of the Roper Logan Tierney model which was described as appropriate to the needs of the residents. It contains nurse-led interventions, an initial assessment and some aspects of a risk assessment.

REHABILITATION TEAM

There is no access to clinical psychology or occupational therapy. There is some access to a social worker. Other staff who visit the residence are a chiropodist and there is access to a dentist and pastoral care.

INVOLVEMENT IN REHABILITATION PROGRAMMES

Each resident has an individual care plan that indicates their level of activity. The activity is linked to the day centre but residents also access community facilities.

CLINICAL RISK MANAGEMENT

There is evidence of policies on clinical risk management. There are some individual clinical risk management assessments within the case notes. There is auditing of serious untoward incidents.

UNIT MANAGEMENT

There are no temporary or permanent transfers to other services due to pressure on beds within the service. All staff within the residence are qualified nurses and there are two nursing staff on duty during the day and one at night. It was highlighted that there was a pilot scheme running recently which ensured that there were two staff on duty at night to accommodate two female patients from the acute unit in Ardee. The outcome of the pilot was that the patients did extremely well on their gradual leave process from the unit, but at the end of the pilot scheme – which ran for three months – the extra nurse was withdrawn and as a result the two female residents have had to go back permanently to the acute ward.

All the staff within the residence are familiar with the routines and are also familiar with the day centre and the Ladywell Centre. The ethos of the residence is to promote independence. There are formal processes for the induction of residents and staff and the appropriate policies and procedures are present. Dress code is casual and appropriate clothing. The only waiting list is for respite care and is managed on a priority basis. Maintenance in the residence is carried out from St. Brigid's maintenance staff in Ardee.

HOUSE RULES

The main rules are around smoking in certain areas and no illegal drugs are allowed within the unit. Visiting times are flexible, residents do not have a front door key but there is free access. The door is open throughout the day. They can lock the bathroom door but not the bedroom doors. Residents are allowed to leave the residence unsupervised but they are asked to tell staff where they are going and what time they will be back. Residents are not required to be out during the day.

Meals are prepared on site. Residents are involved in menu planning and shopping. They also have free access to the kitchen to make drinks and snacks for themselves.

Residents are not required to go to bed at set times or to get up at set times in the morning although they are encouraged to be up for breakfast. Residents have a say in who they share a room with and the bedroom areas are of a reasonable size and standard.

There is a policy in place for the financial management of residents' money. All the residents have a post office account and the post office books go to the post office and the staff collect pensions on a regular basis. It is reported that all the residents are in receipt of the benefits to which they are entitled. Residents have free access to the utility room and are encouraged to look after their own clothing and laundry needs.

Residents are encouraged to interact with services in the community and frequent local shops, pubs and churches. The amenities are within walking distance.

SERVICE USER INVOLVEMENT

It was demonstrable that residents are involved in the care planning process and they also have information available on their treatment and therapies. They all have the right to vote and there is a complaints policy in place.

RECORDS

Residents can access their file. There is evidence of a name and ID number within the case notes, which were reasonably legible and tidy. Entries are signed but there are no progress notes from other health professionals. The initial treatment plan is contained in the nursing file. There was some evidence in the medical files of periodic reviews but there is little written evidence of any medical input.

The nursing notes contain up-to-date and relevant care plans, which are regularly reviewed. The medication system is the same as the other hostels and hospital in the area.

ENVIRONMENT

This was a very pleasant house situated near the town. There was a regular maintenance programme carried out by the hospital. The hygiene within the residence was excellent and the décor was good. The furniture was comfortable and there was plenty of storage space. The lifetime adaptability of the residence could be an issue with regard to stairs as the majority of the bedrooms were upstairs. However this was not a problem at present. The residence consisted of double and triple bedrooms, a lounge, smoke room, toilets, dining room and sufficient baths and showers.

STAFF TRAINING

There is a regional training centre which staff have access to and there are numerous courses available for staff.

RECOMMENDATIONS

CAVAN / MONAGHAN

DEPARTMENT OF PSYCHIATRY, CAVAN GENERAL HOSPITAL

1. There should be occupational therapy input to the unit and activity programmes should be linked to the patients' care plans.
2. The personal alarm system should be upgraded and all staff on duty should have access to an alarm.
3. Any use of mechanical restraint should be prescribed and documented in the patients file.
4. There should be access to a ward clerk.
5. There should be a structure in place for obtaining patients' and carers' views and feedback about the service.
6. All written interventions and prescriptions must be dated, have a legible signature with the name and designation of the clinician clearly printed.
7. A high observation area should be developed for the unit.
8. There should be dedicated beds for the mental health service for the elderly.

ST DAVNET'S HOSPITAL

UNIT 15 (ACUTE ADMISSION)

1. Consideration should be given to develop one of the dormitory areas into an activity room.
2. All policies should be reviewed.
3. The appropriateness of the current shift system must be reviewed to ensure that staff are appropriately deployed within the service.

WARDS 4 AND 8

1. Each patient should have an integrated care and treatment plan that contains a social, psychological, occupational, nursing, psychiatric and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated by the patient's key worker.
2. Occupational therapy staff should be employed in the service and activity programmes should be linked to the patients' care plans.
3. The units should be self-staffing to ensure continuity of care.
4. Any use of mechanical restraint should be prescribed and documented in the patients file.
5. All policies should be reviewed.

COMMUNITY RESIDENCES

1. Each resident should have an integrated care and treatment plan that contains a social, psychological, occupational, nursing, psychiatric and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the resident and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the resident has been involved in developing his or her care plan, and the resident must have a copy of the care plan. The care plan must be co-coordinated by the resident's key worker.
2. There should be a structure in place for obtaining residents' and carers' views and feedback about the service.

3. All written interventions and prescriptions must be dated, have a legible signature with the name and designation of the clinician clearly printed.

LISDARN LODGE

1. There should be a structure in place for obtaining patients' and carers' views and feedback about the service.
2. Residents must have access to an independent advocacy service.
3. The smoking room should be upgraded to ensure appropriate ventilation.
4. Information on training courses should be routinely sent to the residence and consideration should be given to install an IT system.

LOUTH / MEATH

ST BRIGID'S HOSPITAL, ARDEE

OVERALL RECOMMENDATIONS

1. Each patient should have an integrated care and treatment plan that contains a social, psychological, occupational, nursing, psychiatric and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated by the patient's key worker.
2. Occupational therapy staff should be employed in the service and activity programmes should be linked to the patients' care plans.
3. The units should be self-staffing to ensure continuity of care.
4. There should be a structure in place for obtaining patients' and carers' views and feedback about the service.
5. All written interventions and prescriptions must be dated, have a legible signature with the name and designation of the clinician clearly printed.
6. There should be a rehabilitation team. Each patient should be assessed for their future accommodation needs and appropriate resources provided.
7. Residents must have regular physical and mental state examinations and these should be recorded in the patients' clinical file.
8. There should be an increase in the numbers of psychologists, occupational therapists and social workers to ensure that each sector has a core multidisciplinary team.
9. Patients should not be transferred to other units due to pressure on beds.
10. The nursing models in use should be regularly reviewed to ensure that the assessed needs of the patient are being met.
11. Patients should have access to an independent advocacy service.

UNIT 1 (ACUTE ADMISSION)

1. All decisions to admit a patient should be discussed with a consultant psychiatrist.
2. Consideration should be made to reviewing policy on patients nursed in night attire.
3. The alarm system should be updated and regularly checked.
4. The unit should have access to a ward clerk.
5. An induction programme for new staff should be implemented.

OUR LADY'S HOSPITAL, NAVAN

DEPARTMENT OF PSYCHIATRY

1. Each patient should have an integrated care and treatment plan that contains a social, psychological, occupational, nursing and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated by the patient's key worker.
2. Patients should not be transferred to other units due to pressure on beds.
3. The nursing models in use should be regularly reviewed to ensure that the assessed needs of the patient are being met.
4. The ECT facilities must be upgraded to ensure the safe delivery of treatment in an environment that promotes the patients safety, privacy and dignity.
5. All decisions to admit a patient should be discussed with a consultant psychiatrist.
6. Consideration should be made to reviewing the patients nursed in night attire policy.
7. All essential repairs must be carried out and a regular maintenance programme established.

COMMUNITY RESIDENCES

OVERALL RECOMMENDATIONS

1. Each resident should have an integrated care and treatment plan that contains a social, psychological, occupational, nursing and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the resident and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the resident has been involved in developing his or her care plan, and the resident must have a copy of the care plan. The care plan must be coordinated by the resident's key worker.
2. There should be a structure in place for obtaining patients' and carers' views and feedback about the service.
3. All written interventions and prescriptions must be dated, have a legible signature with the name and designation of the clinician clearly printed.
4. A rehabilitation team should be introduced within the service to assist with the rehabilitation of residents in the community. Each resident should be assessed for their future accommodation needs and appropriate resources provided.
5. Residents must have regular physical and mental state examinations and these should be recorded in the patients' clinical file.
6. The units should be self-staffing to ensure continuity of care.
7. Consideration should be made to respect the safety, privacy and dignity of the residents balanced with the risk they may pose in relation to allowing residents to lock their bedroom door.

Cavan/Monaghan, Louth/Meath

ST ANNE'S RESIDENCE, ARDEE

1. There should be an admission policy.
2. Residents should have access to their money as required and be in receipt of regular statements.

RATH NA RÍOGH, NAVAN

1. All essential repairs must be carried out and a regular maintenance programme established.

ST MARY'S, DROGHEDA

1. The draft operational policy should be ratified and implemented.
2. There should be an induction for all new staff.
3. Residents should be involved in menu planning.

DE LA SALLE HOUSE, ARDEE

1. All residents must have access to individual bank accounts and the practice of "pooling" residents' money must cease.
2. All residents should have access to an independent advocacy service.
3. Any upgrading of the accommodation and repairs must be carried out.

AN SOLASÁN, DUNDALK

1. All residents should have a needs assessment undertaken that will determine the most appropriate service to meet their needs. Residents should be transferred to the service best equipped to meet their needs.

Chapter 2

Health Service Executive North Dublin

North Dublin

ST. ITA'S HOSPITAL

ADMISSION UNIT

Date of inspection: *1st November 2005*

Number of beds: *24 male, 24 female*

DESCRIPTION

The admission unit is divided into male and female areas, each with dedicated nursing staff. The dining room is shared between the two areas. The care process is the same in both male and female areas. The unit is single storey and is located in the grounds of St. Ita's Hospital. There were eight detained patients on the day of inspection. Seven sectors and a rehabilitation team have admitting rights to the unit.

REFERRAL

Referrals to the unit come from outpatient clinic, GPs, the A&E department in Beaumont Hospital and occasionally from Dublin Airport. There are also self-referrals to the unit.

PROCESS OF ADMISSION

All patients presenting for admission are assessed on the unit by the NCHD. The decision to admit a patient is made by the NCHD and any difficulties are discussed with the consultant psychiatrist. There are admissions for detoxification and for social reasons. There have been no admissions in the last year of children under the age of 16 years. An assessment form is completed on all patients who are seen but not admitted.

CARE PLAN

There are nursing care plans in operation but there are no multidisciplinary care plans. The care plans are reviewed regularly by the patients' key workers. Discharge planning is done with the patient by the nursing staff, who also complete a discharge summary. There is also a medical discharge form.

NURSING PROCESS

The nursing model in operation is based on the Orem nursing model with some modifications. There is a key worker system in operation. There are three levels of observation: one-to-one observation, high observation and general observation. All patients are checked at meal times and nurse handover times.

ACCESS TO THERAPY

There is no psychological input to the wards. Access to clinical psychology is by referral. There is no occupational therapist. There is a social worker attached to each multidisciplinary team. There are weekly multidisciplinary team meetings on the ward and nurses from both the male and female areas attend. The team meetings are also attended by the social worker and community mental health nurses. The consultant psychiatrists review patients twice or three times a week.

ACCESS TO THERAPEUTIC PROGRAMMES

All activities are based in an adjacent building and are run by nursing staff. Patients are referred through the team meetings and a referral form is filled out on each patient. There are no formal groups on the unit apart from a discharge planning group.

ECT

Although there is a fully equipped ECT suite, no ECT carried out on the unit due to a shortage of anaesthetists. ECT is usually carried out in St. John of God Hospital and the patient is usually admitted there for the duration of the ECT course. Initial ECT preparation is carried out and consent obtained in the admission unit in St. Ita's Hospital prior to transfer.

SECLUSION

There is one seclusion room in each area of the admission unit. The rooms are safe and have a sports finish on the wall. Refractory clothing is compulsory

for each patient in seclusion. The seclusion register was up to date and each patient in seclusion has 15-minute checks.

CLINICAL RISK MANAGEMENT

All policies on patients missing from the unit, the management of violence and searching patients' possessions were available on the ward. New medication policies are also being drawn up. There is a pinpoint alarm system in operation.

UNIT MANAGEMENT

The unit is locked and there is 24-hour security on the door of the unit. Each patient wishing to leave the unit must get permission from the staff prior to leaving the unit. There is CCTV on the external door and in the high observation unit. Patients are frequently asked to sleep in other units due to bed shortages. The unit is self-staffing and continuity of staff is maintained as much as possible.

SERVICE USER INVOLVEMENT

There were notices and leaflets about the service and other health and social services in the unit. There weekly meetings with the advocacy network in the activation unit. A number of patients complained about the smoking areas.

RECORDS

The clinical files were in good condition and showed evidence of regular consultant review. There were up-to-date progress notes that were legible, although some signatures were difficult to decipher and no titles of personnel were used. The medication sheets were in good condition in the male unit but a significant number required rewriting on the female unit. Regular medications, "as required" medications and depot medications were all written in one area which made the medication sheets somewhat confusing. The nurse care plans were all up to date and legible.

ENVIRONMENT

The unit was in urgent need of repainting and decorating. The Inspectorate was informed that re-painting would commence in the next two weeks. Most of the furniture was institutional. The unit was cramped with very little sitting area and with narrow corridors. There was a marked lack of pleasant and comfortable surroundings.

The male unit had a 23-bed dormitory with curtains around each bed and individual wardrobes. There was a high observation area with a bedroom, sitting room shower and toilet and a seclusion room. There was one sitting room with a TV, which was also a smoking room, which was unacceptable, as there was no other sitting area for the patients that did not smoke. The room was drab and uncomfortable. The integrated dining room was functional. There was a visitors' room which was dreary. There was a shower and a bathroom. The toilets were clean. There were two bare interview rooms.

The female area was similar to the male area. There was a 23-bed dormitory. The high observation area contained a seclusion room and a bedroom that had no furniture or decorations apart from one bed. There was a sitting area in the observation area with plastic furniture. There was a tiny smoking room with no extractor fan. There was a small pleasant sitting room. The recovery room of the ECT suite was used a group room and interview room. There were two other interview rooms, one of which doubled up as the CNM2 office.

There was no direct access to a garden space despite the extensive grounds surrounding the hospital. There are plans to develop a dedicated area for a garden and smoking area with direct access from both areas of the unit.

North Dublin

UNIT 1 (MALE AND FEMALE PSYCHIATRY OF OLD AGE)

Date of inspection: *1st November 2005*

Number of beds: *19 male, 20 female*

DESCRIPTION

These two interlinking wards are designated long-stay wards for the care of patients under the care of the Psychiatry of Later Life (POLL) team. These wards share dining and visiting facilities. Due to various problems with leaks, these wards have been in a variety of settings throughout the hospital and are back in the current location for some weeks, thus there are some maintenance matters outstanding. There are two other units under the care of the POLL team, Unit 8, which is an assessment unit, and Unit 9, which is a locked disturbed unit for male patients.

REFERRAL

The residents currently in this ward in general have come here following the closure of other units. Recent admissions have come from the assessment unit and there is a need for long-stay care. A number of patients are booked in on a regular basis for respite to a designated bed. Six patients regularly attend for respite. Referrals to the POLL team come from the GP. New referrals are assessed either at home, in Beaumont Hospital, as an outpatient, or in Unit 8.

PROCESS OF ADMISSION

Despite there being a clear admission protocol procedure for the POLL team this was not available in a documented form on the day of inspection. There were admission policies that applied to the hospital as a whole. There was no written policy on respite available either. Admissions to both these units are generally planned. Occasionally both wards have been used for overflow from the acute units. This is not satisfactory. A detailed assessment protocol is followed in the assessment unit. All patients are known to the service prior to admission to either of these units. Patients admitted are assessed by the duty doctor who also conducts the physical examination. The consultant makes the decision to admit except in the case of the overflow admissions.

All respite admissions are planned for Mondays and the consultant visits on Tuesday so all patients are reviewed within 24 hours. Consultants visit the unit twice weekly. An initial treatment plan is documented prior to admission. A nursing care plan is started on the day of admission and completed within 48 hours. Patients are nursed in their own clothes. There is an observation policy for the hospital with general levels, close unobtrusive levels and one-to-one nursing included. There is a key nurse system in place however there is difficult in maintaining regular consistent staff.

CARE PLAN

There is a hospital policy available on care planning. This is based on the Orem human needs nursing model. This care plan is reviewed at the team meeting every week. The review of the care plans is documented in the case notes. The psychologist and occupational therapist attend the review meetings and are involved in the care planning. Patients admitted to the service tend to be long stay so there is little evidence of any discharge planning. There are plans to move some to nursing homes.

NURSING PROCESS

The model used is the Orem human needs model and it is thought to be appropriate to need. The advantage is that it can address psychological and medical issues. It is very useful because of the family involvement. It does not contain a formal risk assessment. Female nursing staff wear a uniform. Staff do not wear name badges or any form of identification.

ACCESS TO THERAPY

There is a psychologist and occupational therapist on the team. There is no social worker available to the residents in the hospital. There is also a behaviour therapist on the team. There are two consultant psychiatrists on the team and they attend on a twice weekly basis. A visiting GP comes on request. Access

to laboratory, medical consultation is available in Beaumont Hospital. St. Ita's has it own X-ray departments so routine X-rays are performed on site. On each unit there are three nurses and one clinical nurse manager and one care staff per day. On the day of inspection, there were two nursing staff, one CNM2 and three care staff on the female side.

ACCESS TO THERAPEUTIC PROGRAMMES

A number of patients go to therapy in a unit nearby, Aothibhin. This is run by nursing staff, along with a hairdresser and beautician. Some groups are available there. On the ward, when staff have time and when patients are able, there is newspaper reading, reminiscence and old movie viewing.

ECT

There is an ECT suite in the admission unit which is not in use due to the difficulty in obtaining satisfactory anaesthetic cover. Patients have to go to St. Vincent's Hospital, Fairview, the Mater Hospital, or St. John of God Hospital for ECT.

SECLUSION

There is no seclusion in use on either ward.

RESTRAINT

Posy restraints are used in the male side. This is documented in the seclusion and restraint register. This is not countersigned by the consultant. There is a mixture of Kirton and Buxton chairs in use on both sides. The Kirton chairs have been obtained when recommended by the occupational therapist and their use is documented in the nursing care plan. It has been advised that all orders for restraint be made by the consultant and clearly signed in the clinical notes.

CLINICAL RISK MANAGEMENT

There is a safety statement for the hospital. There is no clinical risk management policy available on either side. There is no alarm system in operation. There are policies on patients absconding and on the management of violent episodes. There is a recent medication policy draft which covers issues such as missed and refused doses and this could be expanded to include procedures on giving medication without consent. There are policies on searching patients' belonging. There is a need for a clear written policy on physical and mechanical restraint.

The staff are very satisfied with the level of training provided in control and restraint, de-escalation, breakaway techniques and cardio-pulmonary resuscitation. An Bord Altranais send literature every year updating medication and a pharmacy provides good support. Update courses are provided and legal issues are also covered. In addition, there is training in manual handling and fire and safety.

Individual clinical risk assessments are documented in the patient's chart when carried out. There is a clinical risk assessment form which could not be located during the time of inspection. On checking several charts there was no evidence of any clinical risk assessment documentation. Serious clinical incidents are reported using the standard incident forms. These are sent to the Director of Nursing and the Clinical Director. They are signed by the Director of Nursing. There is a detailed procedure for investigating serious clinical incidents involving inquiries on each incident, particular on the part of medication errors, to check what happened, why it happened and what can be changed. This was a very good procedure protocol. Critical incident debriefing is available following serious incidents.

UNIT MANAGEMENT

There are no temporary transfers out to other units however patients may be transferred from the acute admission unit to create a vacancy there. There are no long-term transfers to other units. This is a locked ward. Some patients are allowed off the ward unsupervised. The door of the unit is always locked. There is no CCTV in use. The ward is not used for any other purposes. There is one domestic staff member on the day staff who is confined to the dining room and kitchen area and spends the day there. There is also a dress code for the household staff. There is no ward clerk and the nursing staff do

venepuncture. At the time of inspection there were two patients waiting for a vacancy on the female side. Availability of non-clinical support staff: availability of maintenance was variable and had to be pushed for. Staff were satisfied with the level of domestic support. Meal times were 0830h, 1230h and 1600h with snacks or drinks at 1100h, 1430h and 1930h. Tea and sandwiches were provided at 1930h and there is tea again at 2130h.

SERVICE USER INVOLVEMENT

There is a notice board in the visitors' area/reception area of the units. There are information leaflets. Patient and family opinions were not formally sought. There were no unit committee meetings of patients. There was a ward complaints policy. There were no information leaflets available on complaints. There was access to advocacy if requested.

RECORDS

The medical files were legible and tidy with regular signed progress notes. A page for the social worker was stored in the back of the chart along with correspondence. Files contained treatment plans. There was evidence of regular consultant review and NCHD review. Entries did not have full names and titles of personnel. The nursing notes were also satisfactory, again omitting the title of personnel. Medication prescriptions and administration records were initialled rather than signed but otherwise were satisfactory.

ENVIRONMENT

The male ward has relocated back to its present location following repair of floor leaks and the female side has been back for the previous three weeks. They were both ground floor units with a number of outside entrances. On the female side, around the entrance area, there was a pleasant visitors' area with comfortable seating and information leaflets available. This was located beside the nurses' station. This did not allow for confidentiality relating to patients in that people outside could see the notice boards with patients' names listed and conversations could be overheard. There was a large day room with a TV, display cabinet, books and video material. The smoking area was the end of this ward. There was a large dormitory off this ward in which 20 beds were located. This was very cramped and overcrowded. There were individual lockers but they were not lockable. There were not enough curtains to go around the beds. Some of the windows had not got the curtains back on them yet. There was little privacy. There was a very institutional feel. The clinical room was off this on the female side and did not have a couch. Dressings were applied in this room where possible. There was also an exit off the ward and two linen storage rooms. The dryer for the unit was kept in the storage room for new clothes.

Despite recent repainting there was evidence of damp on the walls again. A number of the windows have been painted over making them difficult to open. The cords were broken on some of the windows. In general the décor was run down. The main bathroom for the unit had a bath, a shower and a washing machine in it. The shower had disabled access, the bath was rarely used. Off the day room in addition there were toilet cubicles, a sluice room and a staff toilet. The dining room was shared with the male unit as was the visitors' room which was a partitioned area off the dining room. The staff had requested access to a cordoned-off garden area but as this was a listed building this request had not been acceded to. The reception area had a clearly defined area with information boards and leaflets. There was no receptionist. In general the wardrobe space was not adequate and the décor was drab. There was free access to the bathrooms. There were no en-suite facilities. Service was at the table. The dining area was integrated and large. There were male and female kitchen areas off this room and the male clinical room was also off the dining room. There was no separate exercise and activity area, all these activities being conducted off the unit. The lounges on both sides had comfortable seating although more comfortable chairs were requested and awaited. There was no separate quiet area. There was a computer but no Internet access. There was no mouse on the computer on the female side, having been lost in transit. There was suction and oxygen available in the female clinical room and a defibrillator available in the male clinical room which the staff on the female side appeared to be unaware

of. There was a small staff room off the dining room for staff use. Patients received varying amounts of comfort money ranging from €13 to €32 per week. There was a safe on the ward and procedures relating to the handling of money. Medication was kept in the clinical room.

WARD 8

Date of inspection: *2nd November 2005*

Number of beds: *6 integrated*

DESCRIPTION

Ward 8 is a locked unit on the ground floor of St. Ita's Hospital. The ward functions as an admission and assessment unit for the Psychiatry of Later Life (POLL) service. There were five patients on the day of inspection and they ranged in age from 67 to 79 years. All five patients were on Temporary status. There are two consultant-led teams with admitting rights to the unit.

REFERRAL

Referrals usually come from North County Dublin. Referrals come from home via the GP, from the general hospital in Beaumont, from within St. Ita's Hospital and occasionally from nursing homes in the area.

PROCESS OF ADMISSION

Patients are admitted through the POLL service. A full psychiatric assessment is carried out prior to admission. Staff in the unit are notified of the admission and once patients arrive on the unit, they are seen in a waiting area known as "Sans" and then given a full psychiatric and physical assessment in the doctor's room. The consultant psychiatrist makes the decision to admit. Nursing staff introduce the patient to the unit and communicate with the family if and when appropriate. The patient is reviewed by the consultant psychiatrist within 24 hours. Patients are nursed in their own clothes. They are not allocated a key worker due to the high ratio of staff to the small number of patients.

CARE PLAN

There is no multidisciplinary care planning system in operation. Once the patient is settled, a nursing assessment is carried out. Deficits are identified and goals and objectives are set. The nursing care plan is reviewed daily and the goals are reviewed on a monthly basis. Nursing staff try to involve the patient and family as much as possible in the care planning. There is a treatment plan in the clinical file.

NURSING PROCESS

The nursing model in use is the Orem self-care mode. Staff felt that this model places too much emphasis on the physical aspects of care. It does not contain a risk assessment. There are no distinct levels of observation.

ACCESS TO THERAPY

Patients have access to a social work and occupational therapy service by referral from the consultant psychiatrist. There is no psychologist available. Chiropody, dietetic and X-ray facilities are available on campus. The consultant psychiatrists visit the ward twice weekly and there is an NCHD on call. A GP provides an on-call service to the unit. Medical and surgical investigations are provided in Beaumont Hospital.

ACCESS TO THERAPEUTIC PROGRAMMES

A snoezelen room was being prepared on the unit at the time of inspection. Reminiscence therapy is provided by staff on the unit most afternoons and a range of suitable videos are available to assist in this. Music and sing-songs take place. Three of the current patients attend a therapy unit in the hospital specifically for elderly people. Spiritual needs are also catered for.

ECT

There is no ECT on this unit.

SECLUSION

There is no seclusion on this unit.

CLINICAL RISK MANAGEMENT

There is a policy on risk management and a full range of hospital policies were available on the ward. Cot sides are used at the discretion of nursing staff for the safety of some patients. Buxton chairs are used on occasion and this is authorised by the consultant psychiatrist. CCTV is not used and there is no alarm system in place. All staff had received training in crisis prevention intervention and cardio-pulmonary resuscitation. There is a method of reporting and auditing serious incidents.

UNIT MANAGEMENT

There are no transfers to other units. There are occasional transfers of elderly female patients from the admissions unit. The unit is locked for reasons of safety. TV, radio, newspapers and magazines are provided on the unit. The unit is staffed by a CNM2 and two staff nurses by day and one staff nurse at night. There is one care staff and one domestic staff member on duty by day and one care staff on duty by night. There is central rostering on this unit. A ward profile is available to assist with induction of staff. Female nurses and care staff wear uniforms. Phlebotomy services are provided by nursing staff or NCHDs. Visiting times are flexible. Meal times are at 0900h, 1200h and 1630h. Snacks and drinks are provided at regular times during the day.

SERVICE USER INVOLVEMENT

There is a complaints procedure in operation. There is no visit from an advocate but one can be contacted. There is no information and no leaflets are provided on rights or therapies. There is no formal mechanism for seeking the opinions of patients or families.

RECORDS

The clinical files contained the names and ID numbers of patients on the front covers. The files were tidy and legible and they contained treatment plans and progress notes but not in all entries. There was evidence of regular review of patients and records of team meetings were included in the clinical files. The nursing files were in very good order. They were up to date, had entries day and night and showed regular reviews of care plans. The medication prescription sheets were legible and were signed and dated, but the discontinuation of medication was not always signed and dated. There was no separate space on the sheets for prescribing "as required" and depot medications.

ENVIRONMENT

Accommodation on the unit was provided in one single bedroom and three double bedrooms. Staff reported that a seventh bed could be erected if necessary. The day room doubled as the dining room and was in the centre of the unit. There was also a sitting area in an alcove on the corridor. There was a staff kitchen and dining room. There was a clinical room, snoezelen, doctor's office, records' room and an adequate number of toilets, bathrooms and stores. There was a large area off the unit which was used for team meetings and as a waiting area for new patients and their families. A large nursing office had a stand-alone computer. The unit was clean and nicely décorated and had a homely feel to it.

WARD 9

Date of inspection: *2nd November 2005*

Number of beds: *16 male*

DESCRIPTION

Ward 9 is the main building of St. Ita's Hospital. It is a locked ward and the function of the ward is care of patients with enduring mental illness. The majority of patients have been in St. Ita's Hospital for many years. The patients ranged in age from 59 years to 85 years. On the day of inspection, there was one patient on Temporary status and two patients were Wards of Court.

North Dublin

REFERRAL AND PROCESS OF ADMISSION

There have been no admissions to the ward apart from one patient transferred from a nursing home. There are no plans to admit any more patients to this ward.

CARE PLAN

There is a nursing care plan in operation. This is reviewed every three to six months by the nursing staff. There is no multidisciplinary care planning. There is a treatment plan in the clinical file.

NURSING PROCESS

The nursing process is based on the Orem nursing model. There are two levels of observation: one-to-one nursing and general observation.

ACCESS TO THERAPY

There is no psychology, social work, or occupational therapy input on the ward. The consultant psychiatrist attends the ward three times a week to review patients and meet with staff. A dietician visits the ward once a week and a chiropodist is also available. There is also a GP on call for the ward.

ACCESS TO THERAPEUTIC PROGRAMMES

Five patients attend an activation unit in the hospital, where they pack wipes into bags for the hospital and receive €6.50 a day for this work. There are no formal activities for the remainder of the patients. There are newspapers radio and TV on the ward.

ECT

There is no ECT on this ward

SECLUSION

There is no seclusion on this ward.

CLINICAL RISK MANAGEMENT

All hospital policies were available on the ward. There is no mechanical restraint used on the ward. All staff had received training in control and restraint, cardio-pulmonary resuscitation and breakaway techniques, along with other in-service training. There is a serious incident reporting system.

UNIT MANAGEMENT

There have been no additional patients sleeping on the ward due to bed shortages elsewhere, for the past six months. There is no CCTV in use. There are four nurses on duty during the day and two nursing staff on duty at night. There are two domestic staff members on duty. There are no patients waiting for transfer to other units.

SERVICE USER INVOLVEMENT

A notice board and leaflets are available to patients and visitors. There is a complaints procedure in operation.

RECORDS

The clinical files, for the most part, were legible. There was evidence of regular review of patients. Entries did not show the title of personnel. The nursing files were up to date and showed regular reviews of care plans. The medicine sheets were legible, but each prescription was not individually dated. Most patients were prescribed two or more anti-psychotic medications as well as benzodiazepines.

ENVIRONMENT

The ward consisted of a large day room and a large dormitory. The day room had a TV, sofas and chairs. There was a smoking area in the corner of the day room that was not separated from the rest of the day room and had no extractor fan or extra ventilation. This is unacceptable. The dormitory had 14 beds with individual wardrobes and curtains and there were

two single rooms at the end of the dormitory that were bare apart from beds. There were four toilets but no disabled toilet. There was a small clinic room and a very small nurses' office. There was also a small laundry room. There was a shower and bath in one bathroom. There was a locked access to the grounds of the hospital.

AREA 8

CARLTON HOUSE

Date of inspection: *2nd November 2005*

Number of beds: *10 integrated*

DESCRIPTION

Carlton House is a two-storey residence with 24-hour nursing staff supervision close to the village of Lispoppel, Co. Dublin. On the day of inspection, there were six male and four female residents. There are no crisis or respite beds. The age range of patients is between 30 and 60 years. There is a dedicated rehabilitation team, which has admitting rights to the residence. The residence opened in 2001 and it is owned by the HSE. It functions as a rehabilitation residence.

REFERRAL

Referrals come from the St. Ita's Hospital, from the community, and from other residences in the service. Referrals are made to the rehabilitation team. A full psychiatric assessment is carried out prior to admission. Prospective residents visit the residence, are given information about the residence and are then interviewed prior to a decision being made about admission.

PROCESS OF ADMISSION

There is an admission policy in place, which is specific to the high support residences. A history of violence may be a reason for exclusion. People are admitted for the purpose of participating in a rehabilitation programme. Residence staff introduce the new resident to the residence and the rehabilitation programmes. A key worker is appointed who liaises with the family if appropriate. The new resident is assessed by an NCHD within a week of admission.

CARE PLAN

The care plan is nurse led and is based on the care planning system in St. Ita's Hospital. Following an assessment of needs, a care plan is put in place and goals and objectives are set in conjunction with the resident. These are reviewed on an ongoing basis. Discharge planning, such as preparation for independent living, can begin before the admission. There were five discharges from the residence during the past year. None of the current resident group were awaiting accommodation in lower support accommodation at the time of inspection.

NURSING PROCESS

The Orem/Human Care model of nursing is in use. It does not contain a formal risk assessment but issues of risk are identified in the process of assessment. A key worker system is in place. Staff do not wear identification badges.

REHABILITATION TEAM

There is a fully staffed multidisciplinary rehabilitation team in place. An NCHD visits the house each Thursday and the full rehabilitation team visits the house every four or five weeks and reviews the progress of all residents.

INVOLVEMENT IN REHABILITATION PROGRAMMES

Residents are involved in social, recreational and life skills training programmes within the house. There are organised outings several times a week. Residents attend Castle Brook and Laurena day centres on five days per week for individual needs based programmes. Staff bring the residents to the day services.

UNIT MANAGEMENT

There are no temporary transfers to or from the residence due to bed shortages and there are no crisis admissions to the residence. The residence is self-staffing. The residence is staffed during the day by two nursing staff and one care attendant. At night there is one staff nurse and one care attendant. There is no waiting list for the residence.

ETHOS

Carlton House has a philosophy of care which places an emphasis on the value of each individual. The rehabilitative process aims to promote, maintain and restore the health and well-being of each of the residents. There is a policy of induction for residents and new staff and a ward profile to assist in this. There is a range of policies, some of which are specific to high support residences and others which are generic to the service. The dress code in the residence is smart casual.

HOUSE RULES

There are written house rules, drawn up by staff in conjunction with residents. The resident is asked to sign the conditions of tenancy form on admission. There is a designated smoking area. There are rotas for chores within the residence. There are periodic community meetings. Visiting times are flexible. The residents do not have a front door key and are required to check in and out. Almost all residents can leave the house unaccompanied and are encouraged to do so. They are expected to be back at the house by 2200h unless staff are advised otherwise. Residents are required to be out of the residence during the day if possible. Residents have free access to the kitchen. Meals are prepared by staff and residents are involved in the planning of the meals, the cooking and the shopping. There are no set bedtimes but residents are expected to get up at set times on weekdays and weekends. Residents have free access to the laundry room. Most of the residents buy their own clothes accompanied by staff. Some of the residents manage their own laundry. Most residents can access community services on their own, transport permitting. There is difficulty accessing public transport.

SERVICE USER INVOLVEMENT

Information on treatment and therapies, patients' rights and the complaints policy are given verbally by staff. There are no notice boards. There are occasional community meetings. No independent advocate visits the residence.

RECORDS

Clinical notes were in good order and showed evidence of regular review. Residents can access their files. There was evidence that the care plans were reviewed regularly and that progress notes were up to date. The medication sheets were up to date and legible but discontinuation of medication was not always signed and dated.

ENVIRONMENT

The house was a modern, two-storey detached house that was clean, nicely décorated and had a homely atmosphere. The residents were accommodated in three double rooms and four single rooms. The toilet, bathroom and shower facilities were of a good standard. There was a nursing office, a lounge, a kitchen and dining room, and laundry facilities. There were large front and rear gardens. The house was situated in a rural area with some other detached homes nearby. There were no community facilities within walking distance and there were infrequent buses to the nearest town.

INCH HOUSE RESIDENCE, BALROTHERY

Date of inspection: *2nd November 2005*

Number of beds: *9 integrated*

DESCRIPTION

Inch House is situated in Balrothery village near Balbriggan, Co. Dublin. It is a two-storey modern house. The majority of patients have been discharged from long-stay care in St. Ita's Hospital and there are no crisis or respite beds. The age range of patients is between 27 and 69 years. The residence is under the care of a rehabilitation team. The residence opened

in 2003 and is owned by the HSE. There have been three discharges to lower levels of supervision since the residence opened. There are no residents currently ready for discharge to lower levels of supervision.

REFERRAL

There have been few referrals to the residence since it opened but all referrals are through the rehabilitation team. As stated, the majority of residents are referred from long-stay care in St. Ita's Hospital.

PROCESS OF ADMISSION

All patients are assessed prior to admission. A community placement questionnaire is completed on each resident prior to admission. Prospective residents are invited to the residence to meet staff and other residents. Following admission, residents are further assessed using a social functioning questionnaire, and the Positive and Negative Symptoms of Schizophrenia (PANSS) and Camberwell Assessment of Need (CAN) tools.

CARE PLAN

There is a nursing care plan based on the Orem model of nursing care. The care plan is also informed by the assessments carried out on admission. The care plan is reviewed every three months by nursing staff and reported to the team meeting. The rehabilitation team is not a full multidisciplinary team and there was no multidisciplinary care plan in operation.

NURSING PROCESS

There are usually two nursing staff on duty during the day and one nurse on duty at night. There is a key worker system in operation. The rehabilitation programmes are run by the nursing staff.

REHABILITATION TEAM

There is a rehabilitation consultant psychiatrist. However, there is no psychologist or occupational therapist on the team. There is a social worker. There are monthly team meetings in the residence and residents are reviewed at least monthly. There is an NCHD available to the residence. The staff said they were not involved in any rehabilitation management meetings and were therefore unaware of overall plans for the rehabilitation service, waiting lists or planned future developments.

INVOLVEMENT IN REHABILITATION PROGRAMMES

Apart from one resident who is retired, all residents attend vocational training during the day. Some residents attend the National Learning Network. There are individual rehabilitation programmes within the residence based on living skills, budgeting, cookery and social integration. Some residents are on a self-medicating programme. Some residents attend local evening classes as well as swimming.

UNIT MANAGEMENT

There are no temporary transfers due to bed shortages elsewhere in the service and there are no crisis admissions to the residence. The residence is self-staffing which ensures continuity of staff. There is one domestic staff member on duty during the day. There is a waiting list for the unit but information about the waiting list is not available in the residence.

ETHOS

While the population of the residence has been relatively static there is an active rehabilitation programme for residents. There is emphasis on promoting independence within a homely environment.

HOUSE RULES

There are written house rules for the residents and each resident signs a contract to abide by these rules prior to admission. There are rotas for chores within

the residence. Visiting times are open. The residents do not have a front door key but have keys to locked drawers in their bedrooms. Residents are free to come and go during the day but must return before 2200h. There are no set bedtimes. Residents have free access to the kitchen and are involved in shopping for the residence. Staff cook meals and are aided by residents. Residents have their own bank accounts and most manage their own finances. Each resident must contribute €5 for a social fund.

SERVICE USER INVOLVEMENT

Residents are involved in their care plans although there is no written evidence for this. There are meetings between residents and staff every two months. There are weekly menu-planning meetings with residents. There is a village shop nearby and residents are encouraged to use community facilities. There is public transport nearby and a dedicated minibus for the residence.

RECORDS

Clinical notes were in excellent condition and showed evidence of regular consultant review. The medicine sheets were up to date and legible. The care plans showed evidence of regular reviews and progress notes.

ENVIRONMENT

The residence was nicely décorated throughout and was very homely. There was a large kitchen and a dining room. There was a conservatory which was divided into two and used as a quiet area and a smoking area. There was a very pleasant sitting room. There was one double bedroom downstairs with an en-suite bedroom. Upstairs there were three double bedrooms, two of which are en-suite and one single room. There was a large garden and a converted garage which had a pool-table.

KILROCK HOUSE RESIDENCE, HOWTH

Date of inspection: *2nd November 2005*

Number of beds: *12 integrated*

DESCRIPTION

This is a large red-brick period house built in 1875 with rolling gardens and mature landscape situated in Howth with seascape views of Dublin Bay. Since October 2004 Kilrock House has been managed by the St. Ita's Hospital Rehabilitation Service and is described as a high support community residential service. Prior to that it delivered a service on behalf of St. Brendan's Hospital. Thus this is a service in transition. St. Ita's Hospital Rehabilitation Service took over clinical responsibility for the residents living there at the time of transfer of service. Thus residents who were previously being managed in a medium level of support are now managed in a high support residence. Currently 11 of the original residents are still living here. A couple of long-stay patients from St. Ita's have had short stays here but these stays have been unsuccessful.

The age range of residents is from 30s to late 70s, with roughly half over the age of 65.

There are plans to further develop this facility as a community-based vocational training unit to provide active rehabilitation modules for patients with severe and enduring mental illness who require access to a spectrum of vocational training programmes with a more specialised individualised approach, such as is provided by some rehabilitation services for people with autism or Asperger's syndrome disorders.

REFERRAL

All new referrals to the residence have to come through the psychiatric sector team. These referrals are discussed at the referral meeting and if appropriate a detailed assessment is conducted. This includes an in-depth medical assessment of illness history, medication history and current presentation, a nursing assessment and family carer and community support in a social situation. Standardised assessment instruments used include the community placement questionnaire, the everyday living skills inventory, the Functional Assessment of Care

Environment (FACE) and Camberwell Assessment of Needs (CAN).

PROCESS OF ADMISSION

There are detailed community residents' policies available with admission policies of which staff are well aware. Major exclusion criteria are ongoing alcohol or drug problems or unstable mental state with recent violence. Residents are admitted for rehabilitation. It is planned to admit residents for respite if they come from the rehabilitation programme. Admission to this community residence would not be an alternative to an acute admission. The person making the decision to admit is the rehabilitation consultant psychiatrist in conjunction with the team.

CARE PLAN

Currently there is no occupational therapist or psychologist on the team. Thus there was no formal multidisciplinary team care planning although the social worker does attend the clinical review meetings. The individual care plan in use is the same as that in Area 8 in general and is based on the Orem human needs model. The community residential programme is based on the concept of individual care plans which are designed in conjunction with the resident, the rehabilitation team and the relevant family members. These are not formally documented as such although the medical staff document in the clinical files the outcome of the monthly review meetings. At the time of inspection there were several patients awaiting a move to a lower level of support. All the residents are registered with a GP and the staff at Kilrock House communicate with the GP by fax and by telephone. There are strong links with vocational and leisure service providers. Residents sign a condition of residency agreement that covers arrangements regarding finance.

NURSING PROCESS

The nursing process is based on the Orem human needs model which is deemed to be appropriate to need. It does not contain as yet a formalised risk assessment. There is a key worker system and residents know who their key worker is.

REHABILITATION TEAM

There is no clinical psychologist or occupational therapist. There is a full time social worker. The consultant psychiatrist reviews patients at the monthly review meeting where three or four residents are reviewed by the full team. The registrar reviews the residents in between. A senior registrar post has been approved from January of 2006. All residents are registered with GPs.

INVOLVEMENT IN REHABILITATION PROGRAMMES

All residents are involved in programmes to move to lower levels of support and many attend day services off site. Staff do not attend day services off site with the residents. Four patients attend the clubhouse in Suaimhneas in Coolock. One resident engages in part-time work in the local hotel and another is about to take up employment. One resident goes home every weekend and another goes home every second weekend. Residents are involved in daily programmes attending to their activities of daily living, self-medication, public transport familiarisation, social and leisure activities. In addition they have weekly reviews with their key worker. Some are involved in the Solutions for Wellness and smoking cessation programmes. In addition there is a weekly meeting with the residents. There are residents' holidays annually, birthdays and traditional celebrations are marked. One of the issues with this high support residence is that, despite possessing a HACCP kitchen, due to the non-availability of domestic staff all meals are prepared in St. Ita's Hospital and delivered to the unit on a daily basis. Thus residents do not participate in meal planning or shopping. Residents are involved in their own laundry and house cleaning and maintain a high standard in the building. Similarly since the setting up of the team headquarters no domestic support has been provided to the headquarter facilities. There is a clear need for some domestic support.

CLINICAL RISK MANAGEMENT

There was no evidence of policies on clinical risk management or individual clinical risk assessment. Serious incidents are audited in the usual way.

UNIT MANAGEMENT

There are no temporary or long-term transfers from other units. The residence is used as the team headquarters. Nursing staff and care staff provide support to the residents. There are two to three staff on during the day, plus or minus one care staff, and one nurse and a care staff member at night. Care staff attend to the cleanliness of the house and supervise residents doing their daily tasks. This is quite a large area to maintain. Self-rostering applies. It is felt that more domestic support is required in particular in the area of the kitchen so that meals could be prepared on site and so that the office facilities are cleaned.

Community residences have detailed policies and procedures. Staff prior to the move to this residence all received Thorn training. Residents and family level of satisfaction have been measured informally. There is a waiting list for the service in general. No residents have moved to a lower level of support in the last year. Maintenance has been available from St. Ita's Hospital but this is inconsistent and there is not a satisfactory adequate ongoing maintenance programme in place. The refurbishment programme has not yet been completed. There are difficulties in clarifying the budget available to complete the refurbishment programme and staff have no control over this budget. The recreation room is still full of furniture from over a year ago.

The function of this service is still evolving as is its ethos.

HOUSE RULES

There is a contract with residents that outlines the conditions of residency. However this covers issues such as shopping and cooking which no longer apply. They are reviewed at the team meetings. There is no restriction on visiting times. Residents do not have a front door key, but they can lock the bathroom door; the bedrooms are all open and cannot be locked. Residents are allowed to leave unsupervised but are required to check in and out. They are not required to be out during the day. Meals are prepared in St. Ita's Hospital. Residents are not involved in meal planning and shopping. Residents have free access to the kitchen to make drinks or snacks when they wish. Residents are not required to go to bed at set times and are not allowed to smoke in the bedrooms. There is only one single room. Residents were already sleeping in their nominated bedrooms prior to the transfer of services to St. Ita's. There are no facilities to accommodate a visitor overnight. Residents' belongings are not listed. In general residents manage their own finances and there is a policy in relation to this. Residents have independent access to their own money as required and generally have post office accounts. They are in receipt of all benefits and there are no charges since the controversy regarding that issue. Residents buy their own clothes in local shops and have free access to the utility room. Residents' access services in the community unaided and local facilities such as the shops, pharmacy, church are within walking distance and there is access to the public transport service.

SERVICE USER INVOLVEMENT

Information leaflets on national health initiatives are available in the sitting room. There are no leaflets currently about the service. The complaints policy is in line with the HSE policy. Residents' and family opinions are informally sought. There are regular residence community meetings with the residents.

RECORDS

Medical notes in general were satisfactory. Entries had name and date but not the title of personnel involved. They did not contain progress reports from other health professionals. They contained a treatment plan and dated and signed progress reports. There was evidence of review by the consultant psychiatrist on a three monthly basis and NCHDs reviewed on a more frequent basis. The nursing file entry notes were satisfactory, legible and with a signature bank available. Residents are on a self-medication programme and there is a policy in relation to this. Medication prescriptions were

initialled only but they were dated and legible. Entries were signed, dated and again merely initialled.

ENVIRONMENT

Kilrock House is still undergoing a refurbishment process although it is unclear currently how that will proceed. It is a beautiful old house with sea views. There were two entrances to the house. Staff and residents tended to use the side entrance leading directly into the utility area. There was a bedroom on the other side. There were two store rooms and a hall which led to the HACCP kitchen and dining room. There was a large pleasant sitting room with a reading room next to it. In addition there was a boardroom in which meetings and group activities took place and there was an office for a team secretary just inside the front door. Downstairs there was a staff toilet and shower. Sometimes residents were permitted to use this shower.

The side entrance was situated beside a stairs that led directly to the offices of the team headquarters. There was office accommodation for the rehabilitation community team, for the staff of the residents, the social worker, the NCHD, the consultant, the CNM3 and CNM2. These were interspersed with the toilets and bathrooms. There was one bathroom and one shower room and two single toilets along the same corridor. Residents had to go to the toilets in this area although generally the offices were vacant in the evening times.

There was one single room and a room with three beds in which the females were accommodated. The remainder were double rooms. They all had their own wardrobes. The bedrooms and bathrooms were in need of refurbishment. The bathrooms in particular needed to be upgraded. One of the bathrooms had been decommissioned because of the odour. The windows all need to be cleaned. However residents and staff had managed to maintain the building at a good level of cleanliness. Downstairs there was a large conservatory overlooking the beautiful gardens which was used as a smoking room. Staff felt that an outside gazebo for smoking would be helpful. The floors in many of the bathrooms needed to be replaced. Wash-hand basins in some of the room needed to be upgraded. The overall cleaning arrangements needed to be looked at.

STAFF TRAINING

Staff were very satisfied with the amount of training offered and the availability of it. Staff are trained in evidence-based practice, leading empowering organisations (LEO), crisis prevention and intervention, induction for managers and as mentioned had been involved in the Thorn initiative.

WILLOWBROOK UNIT

Date of inspection: *2nd November 2005*

Number of beds: *15 integrated*

DESCRIPTION

Willowbrook is a locked designated rehabilitation unit located on the grounds of St. Ita's Hospital. It caters for 15 patients aged between 24 and 65 years. The residents have a range of severe and enduring mental illness and varying dependency levels. The ward is under the clinical direction of a rehabilitation consultant psychiatrist.

REFERRAL

There are no direct referrals to the unit. All referrals are through the rehabilitation team. Patients are in the main transferred from the acute admission unit.

PROCESS OF ADMISSION

Each patient has a full psychiatric assessment prior to transfer to the unit. The consultant psychiatrist takes the decision to admit a patient to the unit. Patients are assigned general observation level or one-to-one nursing. There is no key nurse system in place.

CARE PLAN

There is no evidence of a multidisciplinary team care plan in operation. There is a typed case summary in each chart. There is no baseline formal assessment in place.

North Dublin

NURSING PROCESS

The Orem King model of nursing is in use. There is no risk assessment and no key nurse system in place.

ACCESS TO THERAPY

There is a limited multidisciplinary team in place. Referral to a named social worker is made at the weekly team meeting. There is no clinical psychologist and no occupational therapist available to the team. The consultant psychiatrist visits twice weekly and as needed. The unit has access to a doctor who provides medical cover. Patients have access to X-ray and dental service on site for a limited time each week. Medical emergencies are dealt with in Beaumont Hospital.

ACCESS TO THERAPEUTIC PROGRAMME

Four patients attend the "Reach" programme facilitated by the National Learning Network in Balbriggan. They are driven there daily by nursing staff. A number of other patients attend an activities programme on site. For some patients there is no programme available. The nursing staff facilitate social outings and the ward has a minibus. There was no feedback on individual performance on any programmes in the case notes and no link with a care plan. Opportunities for rehabilitation or skill building are very limited.

ECT

No patient was in receipt of ECT on the day of inspection.

SECLUSION

There are no seclusion facilities on the ward.

CLINICAL RISK MANAGEMENT

The policies all relate to the HSE Northern Area. There were no policies specific to the ward. There were no policies in place on locking the external door, on "liberty", and on random drug testing, although all were common practice. There was a brief ward profile dated 2005. There was no formal risk assessment completed on each patient. The nursing staff were offered courses on control and restraint. Medical staff update the nursing staff on new treatments. There were two deaths in 2005.

UNIT MANAGEMENT

A number of beds have been used when there is a bed shortage in the acute admission unit. Patients' liberty from the unit is decided by the consultant psychiatrist and documented in the case notes. The main access door is locked. There is no policy in place for this procedure. There is a CCTV camera on the main corridor, but no sign indicating this. There is one CNM2 and three staff nurses during the day and two staff nurses rostered on night duty. The unit is self-rostering. The consultant psychiatrist manages the waiting list for admission but there were no waiting list numbers available on the day. Maintenance is provided by the maintenance department based on the grounds. Meal times are at set intervals and some patients use the local shop during the day.

SERVICE USER INVOLVEMENT

Information is provided on request to patients. Complaints are initially dealt with locally and then if unresolved forwarded to the appropriate personnel as per HSE Northern Area policy. There is no community meeting for residents. The advocacy service does not visit the ward but is available to the hospital.

RECORDS

There were separate medical and nursing notes. The medical notes reviewed showed clear evidence of regular reviews. There were no formal examinations in place. The nursing notes reviewed contained recently rewritten care plans. The chart was neat and manageable. The nursing staff had a signature bank in place, although not dated. The card index system was in order.

North Dublin

ENVIRONMENT

The ward is a single-storey dark building, connected to an adjoining activity unit by a locked door. All of the bedroom areas were locked by day. There were four single bedrooms, a male dormitory area with eight beds and a female room with two beds. The male dormitory was lacking in privacy and inappropriate for the purpose of rehabilitation. There was one shower for 15 patients. The décor and furniture was of a poor standard. There was an internal smoking area and covered external smoking area. There was a lounge area overlooked by a nursing office. There was access to an enclosed garden area.

WOODVIEW HOUSE, PORTRANE

Date of inspection: *2nd November 2005*

Number of beds: *16 integrated*

DESCRIPTION

Woodview House is a residence with 24-hour nursing staff supervision located on the grounds of St. Ita's Hospital. It was opened 15 years ago and is home to 16 residents. On the day of inspection, there were 14 residents in the house, seven male and seven female. The residence is under the clinical direction of a named consultant psychiatrist for rehabilitation. The age profile of residents is from 44 to 67 years.

REFERRAL

All referrals are to the rehabilitation team. The last admission to this residence was one year ago.

PROCESS OF ADMISSION

All admissions are by the consultant psychiatrist. A number of patients from the acute unit are "sleeping out" in times of a bed shortage. The consultant psychiatrist visits weekly and reviews three patients per week. Another doctor deals with medical complaints. A number of the older patients have extensive physical problems.

CARE PLAN

There are no multidisciplinary care plans in place. There is a weekly review meeting attended by medical and nursing staff. There were no discharges last year.

NURSING PROCESS

There is a key nurse system in place. The model in use is the Orem King model. There is no formal risk assessment completed on each resident.

REHABILITATION TEAM

There is a limited rehabilitation team in place. Access to a social worker is by referral. There is access to medical and nursing staff. There is a CNM2 and one staff nurse on duty by day. At night there are two staff nurses on duty. There is also a care attendant and domestic staff member rostered to the residence daily.

INVOLVEMENT IN REHABILITATION PROGRAMMES

Residents are involved in activation-type programmes such as industrial therapy and a "Reach" programme provided off site. A number of residents, due to age, remain in the residence by day. There is no programme in place to actively engage residents in individualised rehabilitation programmes with a view to moving to alternative accommodation.

UNIT MANAGEMENT

The residence currently has two vacant beds. The acute admission unit uses these when a bed shortage arises. The nursing staff are self-rostering, the other care staff are rostered centrally. The residence has a written profile; policies and procedures based on HSE Northern Area policies. Some female staff wear uniforms. There is no formal method of measuring satisfaction with the quality of service. The consultant psychiatrist manages the waiting list and no figures were available on the day.

HOUSE RULES

The rules are designed by nursing staff and primarily focus on smoking. The front door is never locked except by night. Residents have the option of having a key to lock wardrobes. Visitors are encouraged and visiting times are flexible. Residents are not required to be out during the day, but are asked to let staff know if they are away from the house for long periods. Meals are provided in the hospital kitchen and delivered to the residence. Residents are involved in menu choice but have no opportunity to practice skills. There are two single rooms, two triple bedrooms and four double bedrooms. All bedrooms are located upstairs. Residents do not have to be up at a set time at the weekends. A number of the residents are independent in managing their finances. The administration office in the hospital deals with all monies. Currently residents are not paying rent and have received letters regarding this. A number of residents are in receipt of a comfort allowance of €35 per week. Clothing is ordered or bought by the hospital. Residents are given an opportunity to choose from the central supplier. Others use local shops. Residents are assisted with laundry. Community integration is limited by the location of the residence in the hospital. There is a regular bus service to the local villages.

SERVICE USER INVOLVEMENT

Residents are provided with information as requested. Residents have had access to BreastCheck and are encouraged to avail of this check. Complaints are dealt with locally. There is no regular community meeting. The advocacy service does not visit the residence.

RECORDS

There were separate medical and nursing notes. The medical notes reviewed showed evidence of regular psychiatric review. There were no set times or records of physical examinations. The nursing notes contained a care plan and notes were recorded weekly or as needed. The notes were in order and a signature bank was available. No resident was self-medicating. The card index system was in order.

ENVIRONMENT

Woodview House is made up of a pair of two-storey houses knocked into one. All bedrooms were upstairs and separated according to gender. The communal areas include two sitting rooms, an internal smoking room and dining area. The dining area was cramped and as a result meal times were extended to include two sittings. Each resident had a lockable personal locker. There was a nursing office. The building was not lifetime adaptable and this will present difficulties as the residents age. There was no set maintenance programme.

STAFF TRAINING

Training for nursing staff organised centrally. Staff are released to attend courses. Student nurse education is provided in the residence.

ST. VINCENT'S HOSPITAL, FAIRVIEW

PSYCHIATRY OF LATER LIFE UNIT

Date of inspection: *7th November 2005*

Number of beds: *6 integrated*

DESCRIPTION

The Psychiatry of Later Life (POLL) unit is a small integrated locked unit in the grounds of St. Vincent's Hospital. It is an admission unit for patients over 65 years and is under the care of the POLL team. On the day of inspection, there were four patients in the unit and all four patients were on Temporary status.

REFERRAL AND PROCESS OF ADMISSION

Patients are referred to the service by GPs. All patients are assessed by the consultant psychiatrist and community mental health nurses by a home visit prior to admission. Apart from emergency admissions, all referrals are discussed at the weekly team meeting. GPs are notified of patients' admissions.

North Dublin

CARE PLAN

The nursing care plan is based on the Roper Logan Tierney nursing model. Nursing care plans are reviewed weekly. Assessments of patients include the CAPE questionnaire, and the Mini-Mental State Examination. A psychiatric treatment plan is outlined in the clinical file. There is no multidisciplinary care plan in operation. All patients have a discharge plan prior to admission and there are no long-stay patients in the unit. There is an admission and discharge checklist. Some patients attend the service day hospital prior to their discharge.

NURSING PROCESS

There is no primary nurse system in operation as the number of patients on the unit is small. There are two nursing staff on duty during the day and one nurse on duty during the night. There is good continuity of staffing on the unit.

ACCESS TO THERAPY

There is no psychology, social work or occupational therapy input into the unit and these disciplines do not attend team meetings. There is access to occupational therapy through referral by the consultant psychiatrist. The consultant psychiatrist reviews patients regularly and the NCHD attends the unit daily. A consultant physician or geriatrician attends the ward once or twice a week and up to recently there was a physiotherapist available to patients.

ACCESS TO THERAPEUTIC PROGRAMMES

All activities are run by nursing staff. Activities include newspaper reading, crosswords, listening to music and watching videos, and reminiscence therapy. The timetable for these activities is flexible.

ECT

There is no ECT on the unit. ECT is accessed through St. Louise's admission ward.

SECLUSION

There are no seclusion facilities.

CLINICAL RISK MANAGEMENT

Policies were available on the ward. There are unit-specific policies as well as hospital policies. There is ongoing review of policies by the policy committee. There is a pinpoint alarm system in operation. Training in cardio-pulmonary resuscitation, control and restraint and breakaway techniques is available to all staff. There is a serious incident reporting system and staff receive feedback from this. All restraint, including the use of restraining chairs, is documented in the nursing notes, including duration and reason for restraint.

UNIT MANAGEMENT

There are short-term transfers of patients to the ward to alleviate bed shortages in the admission unit and there have been 20 such transfers since January 2005. There is one domestic staff member on duty. The door is locked but the patients have free access to an enclosed garden. There is a ward clerk available to the unit. There is no waiting list for the unit. Meal times are at the usual times and bedtimes are according to patients' choice.

SERVICE USER INVOLVEMENT

There are leaflets and information available on the ward for patients and families. There is input from the Irish Advocacy Network to the hospital. The complaints procedure is available for the patients to access.

RECORDS

The clinical files were tidy and showed evidence of regular consultant psychiatrist and NCHD review. The notes were legible and signed. The medication sheets were in order but there was a complicated system of prescription that could potentially lead to errors. The care plans and nursing notes were in excellent condition and showed evidence of regular review.

ENVIRONMENT

The unit was a small and comfortable. There was a homely combined sitting room and dining room where activities also took place. There were four double bedrooms and a bathroom and shower. One of the bedrooms was an observation room with a window through to the nurses' office. There was access to a newly developed enclosed garden.

ST. CATHERINE'S WARD

Date of inspection: *7th November 2005*

Number of beds: *17 integrated, 10 male, 7 female*

DESCRIPTION

St. Catherine's ward is an integrated ward in St. Vincent's Hospital. It is a locked ward and located on the first floor of the hospital. The function of the ward is continuing care of patients with enduring mental illness. The age range of patients is between 49 and 93 years. A number of patients have a diagnosis of dementia and two or three patients need almost full-time nursing care. A number of patients also have challenging behaviour. On the day of inspection, there were four patients on Temporary status and two in the process of being made Wards of Court.

REFERRAL AND PROCESS OF ADMISSION

Patients are referred to the ward from community residences and nursing home accommodation and through the admission unit. There are occasional direct admissions of patients who have previously been treated in the ward.

CARE PLAN

A nursing care plan is currently being developed which is felt to be more appropriate to the needs of the patient group. All patients are assessed using the Mini-Mental State Examination, the Geriatric Depression Scale and the Brief Psychiatric Rating Scale. Patients are also assessed for suitable activities and there is individual risk assessment on each patient. Both patients and families have an input into the care plan.

NURSING PROCESS

There is a primary nurse system in operation and each patient also has a primary care assistant. There are three or four nursing staff and one or two care assistants on duty during the day. There are two nurses and one care assistant on duty at night.

ACCESS TO THERAPY

There is no psychology, social work or occupational therapy input into the ward and these disciplines do not attend team meetings. There is access to clinical psychology and occupational therapy through referral by the consultant psychiatrist. Nursing staff on the ward are trained in dialectical behaviour therapy and family therapy. There are five consultant psychiatrists with access to the ward and there are regular team meetings and patient reviews on the ward. A consultant physician or geriatrician attends the ward once a week and up to recently there was a physiotherapist available to patients.

ACCESS TO THERAPEUTIC PROGRAMMES

There are activities based on the ward run by a clinical nurse specialist. Programmes such as exercise, relaxation, word games and life skills are available.

ECT

There is no ECT on the ward

SECLUSION

There are no seclusion facilities on the ward.

North Dublin

CLINICAL RISK MANAGEMENT

Policies were available on the ward. There is ongoing review of policies and ward staff are represented on the policy committee. There is a pinpoint alarm system in operation. There is a restraint policy in the process of being developed. Training in cardio-pulmonary resuscitation, control and restraint, and breakaway techniques is available to all staff. There is a serious incident reporting system and staff receive feedback from this.

UNIT MANAGEMENT

There has been no recent short-term transfer of patients to the ward to alleviate bed shortages in the admission unit. There is a waiting list for the unit and this is managed by the placement committee. There is representation from the nursing staff on this committee. One or two patients are awaiting rehabilitation and could possibly eventually be discharged to lower levels of supervision. There is a ward clerk, two domestic staff members daily and contract cleaners twice a week. Meal times are at the usual time and bedtimes are flexible. There is also ongoing team-based performance management on the ward that is specifically looking at personalising patients' areas and improving communication.

SERVICE USER INVOLVEMENT

There are leaflets and information available on the ward for patients. There is input from the Irish Advocacy Network to the hospital but not specifically to this unit as yet. The complaints procedure is available for the patients to access and there is also a suggestion box on the ward.

RECORDS

The clinical files were tidy and showed evidence of regular consultant psychiatrist review. However there was no evidence of regular six-monthly physical examinations. The notes were legible and signed. The medication sheets were in order and legible. The care plans and nursing notes were in excellent condition and showed evidence of regular review.

ENVIRONMENT

Overall the ward was bright and cheerful and all areas were open. There was a sitting room and a dining room that was shared with St. Teresa's ward. A new smoking room needed to be completed which would enable the existing smoking room to be re-furbished and converted to a visitors' room. There was a group room that was used for groups and activities. There were four single bedrooms, one of which was used for special circumstances. The remainder of the sleeping accommodation was arranged in three 4-bed dormitories and one 5-bed dormitory. There were few personalised items but this is currently being addressed through the team-based performance management initiative. There was a quiet room and there are plans to convert this into a snoezelen room. There were two bathrooms but the only shower in the ward was not working and needs to be repaired urgently.

ST. LOUISE'S WARD

Date of inspection: *7th November 2005*

Number of beds: *30 integrated*

DESCRIPTION

This is a 30-bed acute admission ward. It is situated in the grounds of St. Vincent's Hospital. Within the complement of 30 beds there is a 6-bed high observation area. On the day of inspection, there were 13 patients on Temporary status. Five consultant psychiatrists have admitting rights to the unit.

REFERRAL

The sources of referral to this unit are A&E, GP, outpatient clinics, day hospital, An Garda Síochána, family and self-referrals. Referrals are usually initiated through a phone call from the referring agent. There are a number of people who self-refer. The team NCHD, if available, carries out a mental health assessment. If he or she is not available the duty NCHD completes this task.

PROCESS OF ADMISSION

There are no people under the age of 16 admitted and on a rare occasion persons with an intellectual disability are admitted. Patients are rarely admitted solely for detoxification. On admission a full psychiatric assessment is undertaken. There is a very comprehensive three-day nursing assessment in place. On the last inspection, this was a pilot project, but it has now been fully implemented. The patient also has a physical examination and a collateral history is obtained. The NCHD makes the decision to admit a patient and contacts the consultant psychiatrist and bed manager when necessary. Once the decision has been made to admit the patient, they are fully informed and contribute to the three-day assessment. The resident signs the initial plan of care. The patient is reviewed by a consultant psychiatrist within 24 hours and the initial treatment plan is documented within the nursing and medical notes. Patients are not placed in night clothes on admission and there are no specific levels of observation. Since the high observation unit has been developed within the unit all observation levels other than general observation have ceased. There is a key worker system in place, which is based on a team approach.

CARE PLAN

The care plans are predominantly nurse led. Care plans are identified following the three-day assessment. They are needs identified and have specific goals and objectives. There is involvement with other persons in meeting these needs but it was reported there is no access to social work and minimal access to an occupational therapist. A key worker is identified. Care plans are reviewed as needed. The patient signs the care plan and has the option of reading interventions. It was reported that the unit is to pilot a new system of linking risk assessment with discharge planning. Patients' community mental health nurses link with the ward to establish risk issues prior to discharge. It was reported that discharges are planned in consultation with the community teams.

NURSING PROCESS

The unit uses its own nursing model, which is appropriate to the needs of the patients. It is implemented by the key worker and contains a comprehensive risk assessment.

ACCESS TO THERAPY

There is access to a psychology department within the hospital, but there is no access to occupational therapy or to a social worker. There is access to a family therapist and a psychotherapy service. Five consultant psychiatrists have admitting rights to the unit and they undertake a minimum weekly review of all patients on the ward.

ACCESS TO THERAPEUTIC PROGRAMMES

There is evidence of a needs-based group programme. There is a full range of activities available which are planned at a weekly community meeting. The CNM3 oversees the patient activity unit.

ECT

There is an ECT policy and procedure in place. The ECT register is completed and there is documentation of the number of patients who receive ECT. Consent of the patient is obtained by the consultant psychiatrist. There is written ECT information for patients and there is a nursing procedure and checklist. The waiting area for ECT is a relaxation room. There is a preparation room, a dedicated ECT treatment room and a recovery room.

SECLUSION

The seclusion room is situated in the high observation area. There is a seclusion policy and register. There is an observation checklist and a seclusion care plan. The room itself is clean, safe and well ventilated. There is access to a toilet and there is an observation panel in the door. It was reported that the patient is dressed in refractory clothing for safety when placed in seclusion. There is no CCTV in the seclusion room.

North Dublin

CLINICAL RISK MANAGEMENT

There are policies on clinical risk management, alcohol and illegal drug use, patients absconding, the management of violent episodes, giving medication without consent and on searching patients' belongings. It was reported that the staff are trained in control and restraint techniques, incorporating de-escalation and breakaway techniques. There are currently two instructors within the service and there are plans to have two more. All staff receive cardio-pulmonary resuscitation training and the CNM3 is responsible for delivering this. Staff also receive other mandatory training such as manual handling and the preceptorship course. The hospital is linked with the Dublin City University Faculty of Nursing and staff have access to a number of courses within the university.

There is a clinical risk assessment documented in each of the patients' notes. Serious incidents are reported on appropriate forms, which are sent to the Assistant Director of Nursing and forwarded on to a risk assessment team for review. There is debriefing of serious incidents and staff are referred to support services as appropriate.

UNIT MANAGEMENT

Occasionally patients are transferred to St. Teresa's Ward or St. Mary's Ward in the hospital due to pressure on beds. The main reason for this is to prevent people from moving hospitals or area. Patients are transferred on a long-term basis to other units within the hospital. There is a placement committee that meets monthly and plans assessments and placements. There is a full range of activities available to patients on the unit. Patients are allowed to leave the unit subject to the weekly review. The unit is described as open and is locked at night for safety reasons. There is CCTV at the entrance and in the grounds of the hospital.

There are seven nursing staff on duty during the day with a minimum of two of these allocated to the high observation unit. There are four staff on duty at night and again two staff dedicated to the high observation unit, usually male. The unit is self-staffing, thus ensuring continuity of care. There is a process of induction for staff and there is a comprehensive clinical appraisal for newly qualified staff. There is a ward clerk and a phlebotomist available to the unit.

It was reported that there are currently eight patients awaiting placement elsewhere. The majority are awaiting hostel placement but there are few facilities for them to move to. Maintenance is carried out by the on-site maintenance department and it is reported to be a reasonable service. Visiting times are set to avoid clashing with the activity programme and meals. Meals are at set times and snacks and drinks are available between meals.

SERVICE USER INVOLVEMENT

There is information on treatment and therapies available for the patients. There is an information board displaying a number of policies and procedures, leaflets and a complaints policy. There is a weekly community meeting and a suggestion box. At the end of each admission a questionnaire is given to the patient seeking their satisfaction of the service. The questionnaire is anonymous and sent to the Chief Executive Officer. The staff interviewed were not sure what happens with the process following this although it was reported that if there was a complaint the Chief Executive Officer contacts the appropriate Assistant Director of Nursing. There is access to advocacy service.

RECORDS

The records on the unit were of an excellent standard. The medical notes contained the patients' names and ID numbers on all pages. They were legible and tidy. Entries had the full names and titles of personnel and were signed and dated. There were progress notes from allied health professionals who were involved in the patients' care. There is a treatment plan and this was regularly reviewed. The consultant psychiatrist reviews the patients at least weekly and the NCHD reviews more frequently. The nursing files are of an excellent standard. They contain the three-day assessment already mentioned and comprehensive nursing care plans. These care plans are reviewed on a regular basis and there were very detailed progress notes. The drug card indexes were appropriate and all signed and dated.

ENVIRONMENT

This was a 30-bed unit with six dedicated high observation beds. It was reported that the unit is in need of redecoration but this was postponed due to some minor structural work needed to improve the smoking facilities within the unit. There was a clearly defined reception area. This was staffed by a receptionist during the day and security staff at night. There was an information board and available brochures and information. There was adequate seating and an alarm system. There was an assessment room for people presenting for admission with a waiting area and interview office that met with safety requirements. The bedroom areas within the units afforded the maximum safety, privacy and dignity. There was a mixture of single rooms and dormitories with up to four beds. Each area had an individual wardrobe space and curtains around the beds. There was an appropriate number of toilets and bathrooms; bathrooms were kept locked during the day. The dining area had space for all patients at one sitting and was integrated. There was a separate exercise and activity area which had a comprehensive range of equipment. The main lounge area required redecoration and new furniture. It was reported that new sofas had been delivered and that the rest of the furniture will be replaced.

There were two nurse stations within the main part of the ward, one in each corridor. Although small they afforded space for report writing and were confidential. The clinical room was appropriate. It had all the necessary medical and cardio-pulmonary resuscitation equipment. The ECT suite had a dedicated waiting area, a preparation room, treatment room and a recovery room. There was appropriate anaesthetic equipment and there was a maximum of three recovery beds. There was a dedicated high observation area which contained six beds, in four single rooms and one double room. There was an open lounge/dining area that had access to a garden. There were adequate toilet and bathroom facilities. There was a seclusion room within the high observations area. The walls in the seclusion room were clear and the windows were protected and afforded natural light to the room. The door opened outwards and seemed to be solid and of adequate width. There is one recognised blind spot within the room, but there are adequate procedures for dealing with this. Furniture and fittings within the room were a loose mattress which was very low. There was adequate ventilation.

ST. MARY'S WARD

Date of inspection: *7th November 2005*

Number of beds: *9 integrated*

DESCRIPTION

St. Mary's Ward is an integrated admission ward in St. Vincent's Hospital, providing care for private and public patients. It is an open ward and located on the first floor of the hospital. On the day of inspection, there was one patient on Temporary status.

REFERRAL / PROCESS OF ADMISSION

Patients are referred to the ward from GPs and consultant psychiatrists. There are five consultant psychiatrists with admitting rights to the ward. All patients are seen and assessed by the NCHD and the consultant psychiatrist makes the decision to admit the patient. There are no children under 16 years of age admitted and there are no admissions for alcohol detoxification.

CARE PLAN

The care plan is a nursing care plan and consists of a three-day baseline assessment from which a care plan is developed. The patient is involved in the development of its own care plan, which also has a risk assessment and discharge plan incorporated into it. There is an emphasis on solution-based care plans.

NURSING PROCESS

There is a primary nurse system in operation and each patient also has a primary care assistant. There are two or three nursing staff on duty during the day and one nurse on duty during the night.

ACCESS TO THERAPY

There is no psychology, social work, or occupational therapy input into the ward and these disciplines do not attend team meetings. There is access to clinical psychology and occupational therapy through referral by the consultant psychiatrist. There are regular twice weekly team meetings and patient reviews on the ward.

North Dublin

ACCESS TO THERAPEUTIC PROGRAMMES

There are activities based on the ward run by the nursing staff. Activities include living skills, psycho-education, newspaper reading, relaxation art therapy, horticulture, and pottery. Some patients attend the Stress Awareness Centre on the hospital grounds. Others may attend the psychotherapy centre, where there is family therapy, dialectical behavioural therapy and cognitive behavioural therapy.

ECT

There is no ECT on the ward. Patients are transferred to St. Louise's ward for ECT.

SECLUSION

There are no seclusion facilities on the ward.

CLINICAL RISK MANAGEMENT

Policies were available on the ward. There is a pinpoint alarm system in operation. Training in cardio-pulmonary resuscitation, control and restraint and breakaway techniques is available to all staff. There is a serious incident reporting system and staff receive feedback from this. As the ward is an open ward patients requiring more intensive care are transferred to St. Louise's admission ward.

UNIT MANAGEMENT

There are frequent transfers of patients to the ward to alleviate bed shortages in the admission unit. There is sometimes a waiting list for the unit. There is one domestic staff member on duty during the day.

SERVICE USER INVOLVEMENT

Leaflets and information are available on the ward for patients. There is input from the Irish Advocacy Network to the ward. The complaints procedure is available for the patients to access. One patient complained to the Inspectorate of being bored on the ward after activities had finished in the evening. There were regular community meetings with patients on the ward and these were minuted. Patient satisfaction is assessed on discharge.

RECORDS

The clinical files were in satisfactory condition and showed evidence of regular review. The progress notes were up to date and signed. The care plans were also satisfactory. Medication sheets were legible, signed and dated.

ENVIRONMENT

The ward was pleasant and bright. There was a nurse office that offered good observation of the whole ward. There was a pleasant sitting room and dining room as well as a seating area on the corridor. There were two double rooms and the remainder of the rooms were single. All were en-suite. There was also an assisted bathroom and one bedroom was wheelchair accessible.

ST. TERESA'S WARD

Date of inspection: *7th November 2005*

Number of beds: *21 integrated, 13 male, 5 female*

DESCRIPTION

St. Teresa's Ward is a locked 21-bed ward located over three floors. It has a mixed function, providing planned respite care, rehabilitation and continuing care service. All five sector teams have admitting rights to the ward. On the day of inspection, there were two patients detained under the Mental Treatment Act 1945 and one patient was a Ward of Court.

REFERRAL

There are two distinct routes for referral. All respite admissions are planned and booked. Referrals are generally from the community mental health nurse.

Respite periods are for one to two weeks. Admissions to rehabilitation (five beds) and continuing care (12 beds) are from the sector teams to the placement committee within the service.

PROCESS OF ADMISSION

The Functional Analysis of Care Environment (FACE) assessment is completed as a screening tool. The patient has a full mental state examination and physical examination an admission. Each sector consultant psychiatrist visits the ward weekly for case reviews. All admissions are planned. There is a key nurse system in place.

CARE PLAN

There is no multidisciplinary team care plan in place. The placement committee completes a FACE assessment on each individual.

NURSING PROCESS

There are two models of nursing in use. The Roy model is used for the respite and rehabilitation patients. The patients who require continuing care are assessed using an in-house development model. There is no routine formal risk assessment completed on each patient. All nursing staff wear name badges.

ACCESS TO THERAPY

There is no access to social work and access to occupational therapy through a referral system. The hospital has a hospital-based clinical psychology service. Access to this service is by referral. The consultant psychiatrist and NCHD for each sector visit the ward weekly. A gerontologist linked to the Mater Hospital is available for medical consultations. All medical emergencies are directed to the Mater Hospital.

ACCESS TO THERAPEUTIC PROGRAMMES

There is a nurse led activation programme. This programme is struggling to cater for the various needs of the patient group. A small number of patients also attend activities on the acute admission ward.

ECT

There is nobody in receipt of ECT.

SECLUSION

Seclusion is not used on the ward.

CLINICAL RISK MANAGEMENT

These are policies and procedures related to the hospital. All staff carry alarms with the response coming internally from the ward and externally from an emergency response team. Restraint is not used on the ward. All staff are offered courses in mandatory training. These courses are organised centrally and provided in-house. A new clinical risk assessment form is under development and is expected to be in use by early 2006.

UNIT MANAGEMENT

The ward receives patients "sleeping out" from the acute admission ward due to bed shortages. There is a general hospital policy on locking doors. This ward is locked, as are the bedrooms during the day. There are no specific ward policies relating to these practices. One CNM2, two staff nurses and two nursing assistants staff the ward by day. At night two staff nurses and a shared nursing assistant staff the ward. There is one nursing aid and one domestic attendant rostered to the ward. The ward is self-staffed. All new staff receive a formal hospital induction programme and an informal ward induction. The wearing of uniforms by nursing staff is optional. The ward has a ward clerk and there is access to a hospital phlebotomist. There are two waiting lists, one for respite care and the other for the placement committee. There are currently eight patients who could be accommodated in a more appropriate setting. The ward has undergone extensive renovation in the last year. Visitors are encouraged. Meal times are at regular set intervals.

SERVICE USER INVOLVEMENT

Information is provided on request regarding treatment and rights. There is a hospital complaints system in place. A community meeting is held on an ad hoc basis and minutes are kept. The Irish Advocacy Network visits the acute ward and patients are informed.

RECORDS

The records reviewed on the day were in order. The medical chart was neat and easy to manage. There was evidence of regular medical reviews. The nursing notes were also in order. A clear nursing plan was evident and entries reflected goals identified. There were two systems for recording the administration of medication. They were in order on the day.

ENVIRONMENT

The ward has been recently renovated including a new heating system. The ward is laid out over two floors with stairs-only access to the floors. There were four single bedrooms and two five-bed and one six-bed areas. The single rooms had a wash-hand basin and adequate personal storage. The bedrooms were locked during the day. There was a communal smoking room, sitting room and quiet room on the ground floor. There were adequate toilet and shower facilities. There was an external garden area that was accessible only when staff were present.

CONNOLLY HOSPITAL

ACUTE ADMISSION UNIT

Date of inspection: *8th November*

Number of beds: *22 integrated*

DESCRIPTION

The acute admission unit is situated in the basement of Connolly Hospital. The main door to the unit was locked on the day of inspection and was manned by a member of the hospital security staff. Only one half of the unit was in use at a capacity of 22 beds. There were nine male patients and 13 female patients. Six patients had Temporary status. There are three consultant-led teams with admitting rights to the unit.

REFERRAL

The majority of referrals come from the A&E department of Connolly Hospital. Referrals also come from the outpatient department and from the day hospital. There is a full-time liaison consultant psychiatrist and a liaison psychiatric nurse. Out of hours, referrals are seen by the liaison NCHD or the consultant on call. Staff reported that there can be a backlog in A&E and beds have to be sourced elsewhere.

PROCESS OF ADMISSION

According to staff, the admission policy for the new unit is not yet finalised. No children under the age of 16 years are admitted. People with intellectual disability are admitted and there are admissions for detoxification and for social crises. Patients receive a full psychiatric and physical assessment on admission. The NCHDs often make the decision to admit. Nursing staff and NCHDs communicate with the patient regarding their initial treatment plan and liaise with the family if appropriate. The consultant psychiatrist sees the patient within 24 hours. Patients are nursed in their night clothes unless the admitting doctor decides otherwise. The patient is observed every 30 minutes after admission. A key nurse is appointed on admission.

CARE PLAN

Care plans are nurse led. There is no multidisciplinary involvement in the care planning process. The nursing needs are identified and goals and objectives are set. There is a key worker identified. Care plans are reviewed on a regular basis. There is no formal discharge planning.

North Dublin

NURSING PROCESS

The Orem nursing model is in use and it is described by staff as appropriate to the needs of the patients. There is a key worker who implements the care plan. There is no formal risk assessment tool used. Observation consists of a general check every 30 minutes. Special (one-to-one) observation is also used.

ACCESS TO THERAPY

Referrals to other members of the multidisciplinary team are made by the NCHD. There is limited access to a social worker or psychologist due to incomplete multidisciplinary teams. There is an occupational therapy department on site, staffed by two occupational therapists and an occupational therapy assistant. Other therapists, including a behaviour therapist and family therapist are available. The consultant psychiatrists visit the unit at least once a week. The NCHD also makes referrals to the medical and surgical teams within the hospital. X-ray and lab results can be accessed on the IT system.

ACCESS TO THERAPEUTIC PROGRAMMES

There are nurse led group discussions held on the unit on a weekly basis. A number of the patients are referred to the occupational therapy service, where assessments are carried out and a varied programme is offered.

ECT

There is an ECT suite on the unit but it has not been used up to now as there are issues regarding anaesthetist cover which have yet to be finalised. The suite has a designated waiting area, a preparation room with all the monitoring equipment and a clothes store. The treatment room has space for one person. A new ECT machine is on order. The recovery room has all the appropriate monitoring equipment and has capacity for three beds.

SECLUSION

There is no seclusion room and no seclusion is carried out. Prior to the move to the new unit, the policy was to transfer patients to St. Brendan's Hospital if they proved too difficult to manage on the acute unit. Since the new unit opened, no-one has been transferred to St. Brendan's but staff reported that there has been constant need for special (one-to-one) nursing.

CLINICAL RISK MANAGEMENT

The policies that were in use prior to the move to the new unit are still in use and need to be updated. There are policies on risk management, alcohol and illegal drugs, patients going missing and the management of violent episodes. A policy on searching patients' rooms or belongings is being formulated. There is a policy on physical restraint and such restraint is documented. There is a pinpoint alarm system and a response is provided by other staff and hospital security. Staff are trained in control and restraint, breakaway techniques, de-escalation and in cardio-pulmonary resuscitation. Pharmaceutical representatives give lectures to staff every two weeks. There is a system for reporting and auditing serious incidents.

UNIT MANAGEMENT

Some patients have been transferred to St. Patrick's Hospital for a period of about six weeks for ECT. There have been no long-term transfers to other units since the unit opened. TV, radio and newspapers are provided on the unit. Most patients are allowed off the unit and this is documented by the doctor. The policy on whether the unit is locked or not has yet to be finalised. Decisions to lock the unit are documented. CCTV is used at the entrance to the unit. There are five nursing staff on duty by day and three nurses at night. There are between four and six household staff on duty during the daytime. There is unit rostering. There is a process of induction for new staff, who are supernumerary for four weeks and are given an induction course and induction pack. It was reported that nursing staff wear uniforms by choice. There is a full-time ward clerk. A phlebotomist from the main hospital visits

the unit daily. There is a waiting list and a list is kept in the nursing office. Maintenance is provided from within the hospital. There are set times for visiting and for meals. Drinks and snacks are provided and patients can access a vending machine and the hospital coffee shop.

SERVICE USER INVOLVEMENT

Information on treatment and therapies is available through leaflets and videos. There are notices on patients' rights and the complaints policy. There is also a booklet about the unit. There is a community meeting on the unit and the opinions of families and carers are sought informally. An advocate visits the unit. Outside agencies, including the Citizens Information Centre, visit the unit every four weeks.

RECORDS

The patient's name and ID number was not always evident in the medical notes. The notes were legible but not tidy. There were a number of loose pages in each of the files reviewed. Any entries had the full names and titles of personnel and were signed and dated. There were progress reports from other members of the multidisciplinary team. There was generally a treatment plan and signed progress reports. The consultant psychiatrist reviews the patients at least weekly and the NCHD visits daily. The nursing notes were tidy and legible and contained up-to-date care plans which were relevant and regularly evaluated. Drug card indexes were signed, dated, legible, used generic names and discontinuation of medication was signed and dated. The chart of a person who had been involuntarily admitted was reviewed and was appropriate. One of the patients who was interviewed on the inspection stated that although he was Voluntary, he wanted to leave but was threatened with being made Temporary if he signed a 72-hour application for discharge.

ENVIRONMENT

This was a new acute admission ward situated in the Level 1 of Connolly Hospital. The unit was currently half-open providing in-patient beds for the two sectors in Blanchardstown. There are 22 beds. There were a number of maintenance issues with regard to the unit, of particular note is a sewage problem. The décor of the unit was good and there were plenty of information boards with appropriate notices. There was access to a garden and an outside designated smoking area. The reception area, currently monitored by security staff, was situated close to the wards but was isolated.

The bedroom areas afforded as much privacy and dignity as possible. There was a mixture of single rooms and dormitories with a maximum of four people to each dormitory. There were curtains around each of the bed areas; there was a problem identified with the type of curtain rail used. Patients had their own wardrobe spaces. There was adequate numbers of toilets and bathrooms although there were problems with the showers.

The dining area had space for all patients at one sitting, it was self-service and integrated, and there was a good standard of décor. The lounge areas were small, there was comfortable seating and patients had access to newspapers, TV, videos, radios and some books. There were interview rooms available that were soundproofed and located within the main corridor of the ward. There were two nursing stations situated at either end of the corridor. They were of a reasonable size, accessible and with IT and telephone system. The clinical room had all the appropriate medical and cardio-pulmonary resuscitation equipment.

UNIT 3

Date of inspection: *8th November 2005*

Number of beds: *40, currently 12 male and 17 female*

DESCRIPTION

This is a 40-bed service for Psychiatry of Later Life (POLL). It is a locked unit. On the day of inspection, there were 29 in-patients. It was observed that if the unit was full it would be extremely cramped.

North Dublin

REFERRAL

All admissions are planned admissions of community-based patients suffering from dementia with severe behaviour and/or psychiatric symptoms. Their relatives have visited the unit prior to admission to reassure themselves that they are happy with what has been offered. At that stage the patients are admitted to the services acute unit in St. Vincent's hospital as Temporary patients to try and settle their behaviour to some degree and when this has been achieved they are transferred on Section 208 of the Mental Treatment Act 1945 to Unit 3 for long-stay care.

PROCESS OF ADMISSION

Once an assessment has occurred at St. Vincent's the patient is transferred under section 208 of the 1945 Mental Treatment Act. On the day of inspection, there were eleven patients on Temporary status and one Ward of Court. The rest of the patients were on Voluntary status. The NCHD carries out a physical examination. The person making the decision to admit is a consultant psychiatrist. The staff communicate with the patient wherever possible regarding the treatment plan and encourage family contact. There is a key worker system in place.

CARE PLAN

Care plans are nurse led. The nursing needs are identified and routine goals and objectives are established. There is no occupational therapy, social work, psychology or physiotherapy input. Care plans are reviewed every two weeks.

NURSING PROCESS

The unit have developed their own assessment model, which is detailed and is carried out in conjunction with practice development. It contains an assessment that leads to a care plan and subsequent reviews. It was described as appropriate to the needs of the patients and is implemented by the key worker. There are some risk assessments implemented focusing on pressure area care and mobility.

ACCESS TO THERAPY

The unit is staffed by medical staff and nurses. The consultant psychiatrist reviews on a weekly basis and any medical and surgical consultations are with Connolly Hospital. The NCHD visits on a daily basis. A number of the patients respond positively to therapy.

ACCESS TO THERAPEUTIC PROGRAMMES

It was reported that there used to be an activities nurse who attended the unit in the afternoons. This has stopped recently and was identified as a need and there are efforts to try and re-establish this role.

ECT

There is no ECT on this unit.

SECLUSION

There is no seclusion on this unit.

CLINICAL RISK MANAGEMENT

A number of policies in place were in need of review. The unit information folder was informative and detailed. It was reported that staff receive training in crisis intervention techniques for the management of aggression and this includes de-escalation and breakaway techniques. It was reported that there were few episodes of violence or aggression on the unit. There is access to training within the hospital and to a number of mandatory courses. There are close links with practice development and support for long courses. Any serious incidents are recorded on appropriate forms and sent to the risk assessment office where they are processed.

UNIT MANAGEMENT

There are no temporary or long-term transfers from the unit. Patients are not allowed off the unit due to their mental state and the door is locked for safety reasons. The staffing mix is qualified nurses and care

assistants. In the morning there are seven staff nurses and two care assistants on duty. In the evening there are five nurses and two care assistants. At night there are two nurses and two care assistants up to 2300h and after 2300h there are two nurses and one care assistant. The unit is self-staffing. During the morning there are two household staff and one in the evening. There is a hospital induction for staff. Maintenance is provided by the on-site maintenance team and it is reported to be difficult to maintain the building because it is very old. There are plans to move it to another part of the hospital. Visiting times are in line with the hospital policy. There have been occasions where relatives have been able to stay overnight due to the deteriorating health of the patient. There are set times for meals and there is availability of snacks and drinks in between meals.

SERVICE USER INVOLVEMENT

There is limited information on treatment and therapies. There is a hospital policy on complaints. There is a monthly family support group meeting, which the nursing staff facilitate.

RECORDS

The patients' name and ID number is on all pages and the files are legible. It was noted there were a lot of loose pages in a number of the files. Entries had full names and titles of personnel and were signed and dated. There were no progress reports from other members of the multidisciplinary team. There was a treatment plan, which was regularly updated. A consultant psychiatrist carries out regular reviews. Nursing notes were legible and tidy and had relevant care plans, which were regularly reviewed.

ENVIRONMENT

The unit was a stand-alone unit on the grounds of a general hospital. It was a former TB hospital with characteristically large windows. The unit was quite run down and needed refurbishment and painting. The unit was locked on the day of inspection. The unit comprised one long corridor with rooms on either side. A veranda area ran the full length of the unit and was used as smoking area. There was access to a green area which was not gardened. Accommodation was provided on the unit in a range of 4-bedroom and 6-bedroom dormitories. Some of the dormitories were quite cramped but many of the patients had personal effects around their beds and the dormitories had a homely feel to them. The unit was warm although some of the windows, which were old and needed replacing, could not be closed properly. The day room doubled as the dining room and was very cramped. There was a snoezelen room and a small, nicely furnished sitting room that was used as an interview room and a visitors' room. There was a notice board that contained information on patient rights and the complaints policy. There was one shower room and two bathrooms on the unit. Space on the unit was quite limited. The staff lockers were on the corridor and hoists, commodes and trolleys were stored in the bathrooms and washrooms.

MATER HOSPITAL

ST. ALOYSIUS' WARD (ADMISSION UNIT)

Date of inspection: *9th November 2005*

Number of beds: *15 integrated*

DESCRIPTION

St. Aloysius' Ward is a 15-bed admission ward located in the Mater Hospital. It provides a sector service to a population of 32,000 through 10 beds. The remaining five beds are used by the liaison psychiatry service. The service is managed through the HSE, the Mater Hospital and St. Vincent's Hospital, Fairview. The ward is open and on the day of inspection there was one patient on Temporary status.

REFERRAL

Patients are referred to the unit by their GP, outpatient clinics, through the liaison service and through self-referral.

North Dublin

PROCESS OF ADMISSION

Most patients are seen and assessed by the NCHD in the A&E department. The current situation is unsatisfactory as patients are interviewed in curtained cubicles that offer no privacy. There are plans to construct an interview room for the mental health services but work on this has not yet commenced. On occasion, patients with mental health problems may remain in A&E for up to 3 days while waiting for a bed either in St. Aloysius' Ward or in their own sector or catchment area of origin. On the day of inspection, one man had been waiting for two days for a bed in another HSE area. The consultant in emergency medicine stated that recently a 15-year-old patient with mental health problems was waiting for three days for appropriate placement. There are no patients under the age of 16 years admitted to St. Aloysius' Ward. There are admissions for detoxification.

CARE PLAN

The care plan in use is the Tidal model of nursing. There are no multidisciplinary teams and consequently no multidisciplinary care plan. There is a discharge checklist in use.

NURSING PROCESS

There are three staff nurses and a CNM2 on duty during the day and two nursing staff at night. This is felt to be inadequate to provide full and appropriate nursing input. There are difficulties in providing group therapy and activities for patients and on occasion hospital security is called to attend the unit when there is disturbed behaviour on the ward. There is a key worker system in operation.

ACCESS TO THERAPY

No psychologists, social workers or occupational therapists have input into the unit or are part of the sector team. It is possible to refer to psychology services in St. Vincent's Hospital in Fairview. However there are long waiting lists and one patient in the service has been waiting for four years for dialectical behaviour therapy. There are weekly team meetings on the ward attended by the community mental health nurse, consultant psychiatrists, NCHD and nursing staff. Consultations with medical and surgical teams take place on the ward.

ACCESS TO THERAPEUTIC PROGRAMMES

There are currently no therapeutic activities on the ward, the reasons given for this were shortage and high turnover of staff. All activities are unstructured. There is a small gym that is used under supervision and TV and videos and DVDs are available.

ECT

ECT is administered on the ward. There is no preparation room, waiting room or recovery room. The entire process of ECT is carried out in the one room, which is not acceptable. There is a dedicated ECT consultant and an anaesthetic nurse attends the administration of ECT. There is an ECT register, policy and written consent is obtained for ECT.

SECLUSION

There is a seclusion room in the ward. There is a window shutter and paint was peeling around the door. Temperature, ventilation, and light were externally controlled and there was an observation panel on the door. Refractory clothing was not used. There was a safety bed in the room but the walls were hard. There was a convex mirror on the wall but there was a blind area in the room. There was no CCTV. There was a shower and toilet adjacent to the seclusion room. The seclusion register was up to date and there was a seclusion policy.

CLINICAL RISK MANAGEMENT

There were general policies for the Mater Hospital and specific policies for the ward, including searching patients, policies on patients missing from the ward, and policies on medication. Due to the rapid turnover of staff recently, not all staff have yet received training in breakaway techniques, control and restraint techniques or cardio-pulmonary

resuscitation. Serious incidents are reported to the risk management department of the hospital and to the Assistant Director of Nursing.

UNIT MANAGEMENT

No patients are slept in other facilities due to bed shortages. There are ongoing difficulties with patient numbers and as pointed out earlier patients may have to wait for a number of days in A&E for a bed. Nurses did not wear uniforms. There was a noise alarm system in operation but a new pinpoint alarm system had been ordered. There were two household staff on duty during the day. There was a ward clerk, who had no office, and a phlebotomy service was available. The door of the unit is open, however if it is locked for operational purposes there is a record kept of this and it is authorised by the medical staff and CMN3 and reviewed every 12 hours. Visiting times are from 1400h to 2000h at weekends and from 1700h to 2000h during the week.

SERVICE USER INVOLVEMENT

There are community meetings on the ward on a weekly basis and these are minuted. Leaflets about the service are given to patients on admission. Notices on patients' rights and complaints procedures are displayed and there is a suggestion box. There are no advocacy service available but Aware hold weekly meetings on the ward. One patient stated that he was very satisfied with the care he received, but would like access to an outside garden.

RECORDS

The medical files were tidy. In some there was no evidence of consultant psychiatrist or NCHD review for up to six days. In one file there was no evidence that the patient had been assessed since the initial admission entry six days previously. In other files there were daily reviews by either the consultant psychiatrist or NCHD. All files contained a treatment plan. The medication sheets were up to date and were legible. They also contained signatures and annotations by the pharmacist. Some of the nursing files did not contain a completed care plan.

ENVIRONMENT

The ward was small and consisted of a long corridor with rooms on either side. There was a seating area at one end of the corridor with a public phone. There was a small gym with a number of pieces of aerobic equipment. The bathroom, shower and toilet facilities were inadequate. There was a male and female bathroom which was extremely small. There were three female toilets and one male toilet. The only shower in the unit was part of the seclusion suite. There was one single room and two double rooms, both en-suite. There was one 6-bed dormitory and one 4-bed dormitory. There was a relaxation room for which new equipment had been ordered. The seminar room was also used by patients as an alternative sitting room. There was an occupational therapy room with a training kitchen. There was also an interview office and CNM2 office. The sitting room and dining room were combined, with a smoking room adjacent. There was no visitors' room which caused difficulties for children's access visits. There is no access to a garden or outside space.

AREA 7

GALLEN HOUSE RESIDENCE, HOWTH ROAD

Date of inspection: *9th November 2005*

Number of beds: *16 integrated*

DESCRIPTION

Gallen House is a 16-bed residential active rehabilitation residence for adults with enduring mental health problems who have difficulty living independently, within the psychiatric services of Catchment Area 7. The residence is located on the Howth Road. It is staffed by St. Vincent's Hospital. It is an integrated unit with 11 males and four females at the time of inspection.

REFERRAL

Residents deemed to be in need of rehabilitation are referred to the placement committee. The placement committee then refers on to whichever staffed

residential unit is deemed appropriate. The placement committee is represented by members of the multidisciplinary teams within Area 7 Mental Health Service. This involves a representative from each of the community residential settings, in-patient units, occupational therapy, consultant psychiatrists and Assistant Directors of Nursing. The role of the committee is to identify the most appropriate placement for residents referred within Area 7. The committee meets once a month to review current and new referrals. Each person admitted to Gallen House has a comprehensive pre-assessment completed by the rehabilitation placement committee which uses the Functional Assessment of Care Environment (FACE) profile. After the committee refers on to Gallen House, generally, a senior nurse from Gallen House meets with the resident and introduces them to the service. Prior to any referral being completed the referral agent needs to consider the following criteria: if the person has a primary diagnosis of a severe and enduring mental illness, if the person has had a duration of stable health, if the person agrees to placement, if the person agrees to engage in the rehabilitation process, i.e. a day activity programme. The community mental health nurse continues to play an integral role in the placement process. The family agree with the placement where possible and patients who require nursing home placement remain the responsibility of the sector team, and the committee is kept informed. In addition to completing a referral form the sector team completes a FACE profile, a FACE risk assessment if applicable, and provides supporting collateral information that may include occupational therapy reports, psychology assessments, physical health reports if applicable and in addition medical and nursing information.

PROCESS OF ADMISSION

The process of admission to the residence is a gradual process. Residents are admitted to Gallen House for rehabilitation and it is not used as an alternative to acute admission. There may be short-term admissions depending on bed availability. There are no admissions for detoxification or respite. There is a policy on residents going out on pass or being moved to create a vacancy. The placement referral committee in conjunction with the staff in Gallen House make the decision to admit and the resident is involved in the referral process and assessment. If the residents become unwell, requiring in-patient care for a prolonged period of time, the vacant bed is used to take transfers from the acute ward. Following admission into Gallen House residents are usually seen at the clinic within a week. There are strong links with the community psychiatric nurse. The nursing philosophy's care is holistic and underpinned by the philosophy of the Tidal model. An "Active Rehabilitation Plan of Care" is introduced for each resident. This identifies the rehabilitation needs, short-term and long-term goals and nursing interventions. The resident signs the care plan as does the nurse and evaluation dates are set. Each resident is assigned a primary nurse or key worker and an associate nurse. This assignation depends on the needs of the resident and individual case load.

CARE PLAN

There is no formal multidisciplinary care planning at present. Each resident has full access to the members of the sector multidisciplinary team. At the time of inspection two residents were planning to move to accommodation with a lower level of support.

NURSING PROCESS

The Tidal model has been introduced in the last year. Staff feel this is appropriate to the residents' needs and that it is put in user-friendly language. It is implemented within two weeks of admission. Recently admitted residents now have a FACE risk assessment, and to date one resident in the unit has had one performed. There is a key worker system as mentioned.

REHABILITATION TEAM

There is no formal rehabilitation team. All residents are managed by their individual sector teams. Clinical psychology is accessed centrally. Many of the teams have behavioural therapists. Dialectical behaviour therapy and cognitive therapy are also available. The consultant psychiatrist is available at the sector clinics and this is arranged through the clinic. All residents are registered with a GP and are able to access the GP by themselves.

North Dublin

INVOLVEMENT IN REHABILITATION PROGRAMMES

There was evidence of needs-based individual programmes and some of the residents were involved in programmes to move to lower levels of support. Residents attend day services off site by themselves and are involved in vocational rehabilitation depending on the level of need. Residents participate in all aspects of keeping the house clean and tidy. Most of them now purchase their own personal hygiene requirements. An evening group social skill event programme has been developed.

CLINICAL RISK MANAGEMENT

There was a healthcare safety statement. A FACE risk assessment is carried out on new residents being admitted to the service. There are alarms in strategic areas that link up with the Garda station. There is a policy on alcohol and illegal drugs. There is no specific policy on residents missing but it is a part of the hospital policy. There is no policy on searching residents. In general, residents' rooms or bed areas are not searched. Individual clinical risk assessments are performed when necessary. Serious clinical incidents are reported on a standard incident report form, according to the HSE Area policy. The area manager manages complaints and serious clinical incidents are audited. Debriefing is available from the HSE Northern Area following a serious incident.

UNIT MANAGEMENT

Residents are occasionally (c. three or four times a year) transferred from the acute unit to free up a bed in the acute unit. These residents would be on the placement waiting list, awaiting a bed. This unit was set up following the closure of a hospital ward. The residence is not used for any other purposes. There are two nursing staff and one care staff on by day and one nurse and one care staff on by night. Staff are rostered to the unit. In addition there is a cleaner in the unit five days a week for four hours. There is an induction programme for staff with a checklist. This is a formal process. There are policies and procedures present. An annual report is compiled. Residents' or families' level of satisfaction is not formally assessed. The waiting list is managed through the placement committee. Two to three residents are discharged to lower levels of support in a year.

Maintenance is provided by St. Brendan's Hospital and this is deemed not to be satisfactory. The shower has not been functioning for the past two years. There is no ventilation in the utility room and the utility room has as a result been decommissioned resulting in all clothes going to the local launderette. Plans have been drawn up for a new laundry. House money comes from the HSE Area and covers the laundry costs. There are problems in providing cover for annual leave of household staff.

The emphasis is on active rehabilitation. The nursing philosophy's care is holistic and underpinned by the philosophy of the Tidal model. An "Active Rehabilitation Plan of Care" is introduced for each resident.

HOUSE RULES

The rules are part of the induction kit and are described as guidelines. They are displayed in the dining room. Visiting times are flexible although not encouraged during meal times. Residents do not have a front door key, though they can lock the bathroom door and can lock the bedroom door, depending on a need and if requested. Residents are allowed to leave the house unsupervised but they are requested to inform staff. Residents are not required necessarily to be out during the day. Seven days a week the meals are prepared by the household staff. Meals are prepared on site. Residents are not involved in meal planning or shopping, although they may state their preferences. Residents do not have access to the kitchen to make drinks or snacks. Residents are not required to go to bed at set times. In the last year Gallen House has become a non-smoking residence. A new smoking shed has been provided outside for the residents who smoke. There are no facilities for overnight visitors. Residents are required to get up at a set time during the week depending on where they are attending. However this is flexible at the weekend. Residents' belongings are not listed.

Some residents are on budgets. All are involved in a budgeting programme. A policy on financial management is being planned. Some residents hold a bank card and the bank cards are kept in the nurses'

office as part of a budgeting programme. Money is collected by the residents themselves. Residents are in receipt of all benefits. They are not asked to pay for any furniture or fittings for the residence. At the time of inspection residents were not paying for any expenses in the residence. Residents buy their own clothes in the local shops and do not have access to the use of the utility room. Residents can access services in the community unaided, such as the shop, pub, banks, church, town. The local facilities are all within walking distance and there is good access to public transport.

SERVICE USER INVOLVEMENT

Information on rights, complaints and national health initiatives is provided in the day hospital. Some of the residents have voting cards although not all. Information leaflets about the service are in place. There is a hospital-wide complaints policy which is followed up through the CNM2. There are irregular meetings with the residents and a suggestion box is provided. There are irregular residence community meetings with the residents, families and carers. There is an advocacy service available which is based in St. Vincent's Hospital, Fairview.

RECORDS

Medical records are kept in the outpatients. Assessments and rehabilitation care plans were available on the unit.

ENVIRONMENT

This is an attractive two-storey house that blends in with the neighbourhood. There was one downstairs single bedroom with en-suite facilities, a shower, toilet and hand basin. There were seven single rooms and four double bedrooms upstairs. All of the bedrooms had wardrobes, were bright, had windows and lots of personal effects. The double rooms were a little bit small. There was one bathroom upstairs with a wash-hand basin that needed repainting. There was one male toilet upstairs with a wash-hand basin and one female toilet upstairs with a wash-hand basin. There has been one shower room in the residence since April 2004. Downstairs there was a spacious entrance hall with a nursing office on the right-hand side. There was a bedroom, previously mentioned, a storage room, one staff toilet and shower. There was a utility room which was out of action and a kitchen with a storage room as well. There was one large dining room and two sitting areas. There was a TV at the back of the house leading out into the garden area, which now has a smoking shed. There was no visitors' area. One of the concerns about the environment is that there is no regular ongoing maintenance programme in place. This service is provided by St. Brendan's Hospital.

STAFF TRAINING

There is extensive in-service education available including preceptorship training, manual handling, clinical supervision, non-violent crisis intervention training, occupational first aid courses, breakaway training, new nursing staff training course, on site fire training and induction programmes. The Leading and Empowered Organisation (LEO) Training has also been attended.

The staff have to be commended in Gallen House for the number of initiatives they have taken in terms of research, annual reports and service development.

GRACE PARK GARDENS, DUBLIN

Date of inspection: *13th November 2005*

Number of beds: *16 integrated*

DESCRIPTION

This residence consists of two interconnecting terraced houses in a residential area near St. Vincent's Hospital. It provides a home and settled environment for residents who have been in the service and is staffed 24 hours a day.

REFERRAL

Residents deemed to be in need of rehabilitation are referred to the placement committee. The placement committee then refers on to whichever staffed residential unit is deemed appropriate. The placement

committee is represented by members of the multidisciplinary teams within Area 7 Mental Health Service. This involves a representative from each of the community residential settings, in-patient units, occupational therapy, consultant psychiatrists and Assistant Directors of Nursing. The role of the committee is to identify the most appropriate placement for residents referred within Area 7. The committee meets once a month to review current and new referrals. Each person admitted to Gracepark Gardens has a comprehensive pre-assessment completed by the rehabilitation placement committee which utilises the Functional Assessment of Care Environment (FACE) profile. After the committee refers on to Gracepark Gardens, generally, a senior nurse from the residence meets with the resident and introduces them to the service. Prior to any referral being completed the referral agent needs to consider the following criteria: if the person has a primary diagnosis of a severe and enduring mental illness, the person has had a duration of stable health, if the person agrees to placement, if the person agrees to engage in the rehabilitation process, i.e. a day activity programme. The community mental health nurse continues to play an integral role in the placement process. The family agree with the placement where possible and patients who require nursing home placement remain the responsibility of the sector team and the committee is kept informed. In addition to completing a referral form the sector team completes a FACE profile, a FACE risk assessment if applicable and provide supporting collateral information that may include occupational therapy reports, psychology assessments, physical health reports, if applicable, and medical and nursing information.

PROCESS OF ADMISSION

Specific policies for staffed residential units have been developed. Again staff meet with the patient prior to admission to the service. There are gradual visits to the unit and overnight stays. Staff emphasised that the main criterion for admission was the resident's wish to go there. Residents are admitted for continuing care and for rehabilitation. There are no admissions for respite care or as an alternative to acute admission. There are no admissions for detoxification. A placement committee, along with the staff from the unit, make the decision to admit.

Residents are reviewed in the clinical outpatients every couple of weeks. If there is a crisis they are accompanied to St. Vincent's Hospital, Fairview by the staff. All residents have a key nurse assigned, and an associate key worker from the care staff. The medical notes are kept in St. Vincent's Hospital, Fairview.

CARE PLAN

There is no multidisciplinary care plan assessment.

NURSING PROCESS

The Tidal model is gradually being introduced and is being assessed and audited by the staff. A FACE risk assessment is conducted when residents are deemed to require it.

REHABILITATION TEAM

There is no formal rehabilitation team. All residents are managed by their individual sector teams. There is no psychology service available. Many of the teams have behavioural therapists. Dialectical behaviour therapy and cognitive therapy are also available. There is good access to the occupational therapy for all the residents but no social work service is available. The consultant psychiatrist is available at the sector clinics and this is arranged through the clinic. All residents are registered with a GP and are able to access the GP by themselves or accompanied by staff.

INVOLVEMENT IN REHABILITATION PROGRAMMES

There was evidence of needs based individual programmes and all residents were involved in programmes to move to lower levels of support. Residents attend day services off site by themselves and are involved in vocational rehabilitation depending on the level of need. Residents participate in all aspects of keeping the house clean and tidy.

Residents attend Tús Nua, Ard Nua, St. John's in Plunkett's College and New Century House. There are

no groups conducted in the house as it is desirable to maintain a home-like environment. There are budgeting programmes and outings.

CLINICAL RISK MANAGEMENT

New residents to the service have the FACE individual risk assessment. Incidents are audited in the standard way. There is extensive in-service education available including preceptorship training, manual handling, clinical supervision, non violent crisis intervention training, occupational first aid courses, breakaway training, new nursing staff training course, on site fire training and induction programmes. The LEO Training has also been attended.

The staff have to be commended in the Gracepark Gardens for the number of initiatives they have taken in terms of research, annual reports and service development.

UNIT MANAGEMENT

There are no temporary transfers or sleeping out, or long-term transfers to other units. The residence is not used for any other purposes. The residence has 100% occupancy. The daytime staff complement are an Acting CNM2, Acting CNM1 and two staff nurses (one full-time and one for 30 hours a week). There is one full-time staff nurse and two job-share staff nurses on night duty. The ancillary staff complement includes two full-time nurses aides, one full-time domestic staff member Monday to Friday, one cook 20 hours a week. Unusually, there is a clerk for three hours on Monday and Wednesday and from 1000h to 1700h on Thursday.

The ethos of the residence is based on individuality and respect and an attempt is made at every opportunity to address the imbalance of the effects to the person of prolonged hospitalisation. An annual report and audit is compiled. There is an informal process of induction for residents and staff. Policies and procedures are being developed for community residents. Resident meetings are conducted every four to six weeks. The audit conducted in the service involved interviewing all the primary nurses and addressing key areas. The waiting list is managed by the placement committee. In the last year one resident was discharged to a lower level of support.

HOUSE RULES

House rules are individually tailored. The major rule is dignity and respect of all residents and staff. The rules are designed with the residents and a resident agreement is in development. Visiting times are flexible during the day and discouraged after 1930h to 2000h. All residents have a front door key. Residents can lock the bathroom door but they cannot lock the bedroom doors. Residents are allowed to leave unsupervised but they are required to notify the staff about their movements. They are not required to be out during the day. The cook or care staff prepare the meals on site. Residents are involved in meal planning and shopping. The meal planning may be decided at the residents meeting. Residents do not have free access to the kitchen to make drinks or snacks as due to the boiler they must always be supervised. Residents have flexible bedtimes and are not allowed to smoke in the bedrooms. As far as possible residents can select whom they share with. There are two single rooms and several double rooms. There are no facilities for an overnight stay. Residents are called in the morning and encouraged to get up. Residents' belongings are not listed.

As far as possible residents manage their own money. Some of them are on a budgeting programme. There are guidelines for the collection and money management in Gracepark Gardens. Not all residents have bank cards but they have independent access to their own money as required, depending on their mobility etc. The clerk collects money for six of the residents who are confined or physically unable or vulnerable. Residents are in receipt of all benefits. They are not asked to pay for new furniture or fittings for the residence. Residents buy their own clothes in the local shops. The residence has a no smoking policy, however between the hours of 2300h and 0600h, residents can smoke in one designated area. Residents have free access to the use of the utility room. Some require staff support. Residents access services in the community unaided such as the cinema, shops, the 245 Club, Weight Watchers, church. The local facilities are within walking distance and there is access to public transport.

SERVICE USER INVOLVEMENT

Information leaflets about the service are being developed. There is information available such as on the right to vote, rights, and public health initiatives in the day centres and day hospital. The staffed residential units follow the St. Vincent's Hospital policies. There are regular residence and community meetings and there is access to the advocacy services.

RECORDS

Records are not kept in the residence. Residents are not on self-medication programme. The veno-link blister pack system is used. Medication prescription and administration records were satisfactory in all respects.

ENVIRONMENT

There were seven double bedrooms and two single bedrooms available. In addition there was one bedroom for care staff at night. The house on the left-hand side was in need of considerable refurbishment and upgrading. There was a shower-cum-toilet and wash-hand basin downstairs. The toilet is continuously running and the shower needs to be upgraded – there is a problem obtaining hot water. With regard to the dining area, there were two inter-connecting dining areas to the rear of the house and on one side there was a kitchen for fridges and storage and on the other side there was a kitchenette to which residents did not have access. Outside there were tables and chairs on one side with a smoking area. In the yard outside to the back on the left-hand side the ground is unsafe and needs to be repaired. The oil tanks are on this side. There was a pleasant upgraded sitting room on the right-hand side with a TV. On the first floor there was a recently upgraded sitting room with new leather suites and pleasant furnishings. The clinical room is also upstairs and contains medications and depots. There was another double room on this floor. On the first floor on the right-hand side there was a staff toilet. There was extensive staining on the bath, which was very unappealing but difficult to remove, due to potassium permanganate baths being taken. There was a staff sleep-over room, toilet and sink. On the second floor on the left-hand side again all the bathrooms need upgrading. The windows were broken in the top bedroom, causing a draft. There is a kitchenette which has been decommissioned in that bedroom. There were store rooms, double rooms. There were wardrobes in all the bedrooms that were packed full. The house was clean but cramped.

ST BRENDAN'S HOSPITAL

3, 4 AND 5 GRANGEGORMAN VILLAS

Date of inspection: *9th November 2005*

Number of beds: *10 integrated, 9 male, 1 female*

DESCRIPTION

Grangegorman Villas are located near St. Brendan's Hospital. The residence is about to be relocated to a refurbished premises. The age range of residents is from 28 to 65 years. The emphasis is on providing continuing care to residents and there are no residents suitable for discharge to lower levels of supervision.

REFERRAL / PROCESS OF ADMISSION

Most residents are referred from St. Brendan's Hospital. Others are referred from other supported residences in the service. There were two recent admissions to the residence following a ward closure in St. Brendan's Hospital. Due to the sudden closure of this ward there was little preparation of these two residents for discharge to the residence. There are no respite or crisis beds. The staff are informed by the consultant psychiatrist of any admissions to the residence and there is no formal assessment of patients prior to admission. All admission procedures are carried out prior to admission to the residence.

CARE PLAN

There is a nursing care plan based on the Orem model of nursing. Each resident has had a Morningside Rehabilitation Scale administered. Some, but not all, residents had a community placement questionnaire completed. There is an individual service plan that addresses areas such as living

situation, physical health, psychiatric health, education and vocational training, daily living activities, leisure, finances and community network. These are reviewed on a yearly basis. It was stated that there has been a risk assessment on each resident. However copies of these were not available in the residence at the time of the inspection. There is no formal discharge plan.

NURSING PROCESS

There are two nursing staff on duty during the day and one nurse on duty at night. There is a primary nurse system in operation.

REHABILITATION TEAM

It was reported that the components of the rehabilitation team consist of a consultant psychiatrist, nursing staff, NCHDs, occupational therapist and 0.5 whole-time equivalent of a social worker. There is no psychologist on the team. Residents attend the outpatients department and there is a team meeting every two weeks.

INVOLVEMENT IN REHABILITATION PROGRAMMES

There are few activities for the residents. One resident is on work placement. One acts as a messenger for the residence.

UNIT MANAGEMENT

There are occasionally patients from St. Brendan's Hospital sleeping over in the residence due to bed shortages. There is one domestic staff member available to the residence. There is central rostering of staff throughout the residences. There is no waiting list for the residence but vacancies are filled promptly. There is a dog which is looked after by staff and residents.

HOUSE RULES

There are house rules regarding smoking. Bedtimes are flexible and visiting times are open. Most residents have a front door key. Residents are allowed to leave the residence as they wish. Few residents are involved in shopping for food or preparation of meals. Residents collect their own allowances but may be accompanied by staff if necessary. Residents have their own post office books. Residents' cash is stored by the staff but can be withdrawn at any time by the resident. Residents are accompanied by staff when buying clothes.

SERVICE USER INVOLVEMENT

There are monthly community meetings but no minutes are taken. Residents access the local shops and services and use the local bus routes. Information about the residence is given verbally by the staff. There is a complaints procedure for residents and it is available on request. There is access to advocacy services within the service.

RECORDS

The medical files had some evidence of clinical reviews. The nursing care plan system was in need of review. There was little space to write reviews or evaluations of the care plans. There was limited involvement of residents in the care planning process. There were no written interventions by any other discipline of the multi disciplinary team.

ENVIRONMENT

The environment was very poor and the residence was extremely dirty. The bedrooms were small and cold. The toilets and bathrooms afforded limited privacy and were in a bad state of repair. The accommodation is due for closure in the near future.

North Dublin

175 NAVAN ROAD, DUBLIN

Date of inspection: *9th November 2005*

Number of beds: *19 integrated*

DESCRIPTION

This is a 10-bed community residence with 24-hour nursing staff supervision. It was opened in 2005 and on the day of inspection there were eight male residents and two female residents.

REFERRAL

The source of referral is St. Brendan's Hospital and other residences in the area. The process of referral was the residents were identified within current services and assessed to ascertain their suitability for transfer to 175 Navan Road.

PROCESS OF ADMISSION

It was recognised that this is a new service and a number of policies and procedures need to be developed. Currently there is no admission policy but it was reported a policy will be developed in the near future. The only exclusion criteria are a recent history of violence and residents must agree to comply with individual and group programmes. The main reason for admission is to participate in a rehabilitation programme with an emphasis on moving on to a lower level of supported accommodation. Each resident was assessed prior to transfer. This was a comprehensive assessment which involved a number of disciplines. All residents are registered with a GP. The decision to admit was a team decision. It was reported that it is very important for the resident to adhere to the programme and consequently the nursing staff spend a lot of time in communication with the residents regarding their treatment plan. Contact with family is also encouraged. There is a key worker system in place and it is of note that the key workers are from different professional backgrounds.

CARE PLAN

The care plan is multidimensional and is based on the Functional Analysis of Care Environment (FACE) assessment which incorporates a risk assessment. It is needs identified and involves all the appropriate people in meeting the residents' needs. Goals and objectives are identified and a key worker nominated. The care plans are reviewed as per need and there is documented evidence of the involvement of the resident. Currently it is too early for a discharge plan for any of the residents.

NURSING PROCESS

As described, staff use the FACE assessment which is appropriate to the needs of the residents and implemented by the key worker in conjunction with the multidisciplinary team.

REHABILITATION TEAM

There is access to a clinical psychologist via a referral system. There is a part-time occupational therapist working in the residence and access to a social worker. There is one consultant psychiatrist available who carries out fortnightly reviews either in outpatient clinic or on site. The staff reported that they are in the process of registering the residents with local GPs.

INVOLVEMENT IN REHABILITATION PROGRAMMES

It is planned that this service will have a comprehensive needs-based individual programme. It is hoped that all residents will eventually move on to a lower level of support. Residents are attending services off site.

UNIT MANAGEMENT

There are no temporary transfers in or out of the unit. Staff within the residence are qualified nurses. There are two on duty during the day and one staff nurse and a care assistant at night. The staff are rostered via a central rostering system and it was reported that they would prefer to be a self-staffing unit. There was one domestic staff member. The ethos of the residence is to provide rehabilitation into the community.

HOUSE RULES

The house rules are designed by the staff in conjunction with the residents. The residents undertake that they will actively partake in their programme which will include cooking, cleaning and other individual aspects of an assessment. Visiting times are open. The residents have a front door key and they are allowed to leave unsupervised. Residents are requested to let staff know where they are going and when they will be back. Meals are prepared on site by the household staff. There is some assistance by the residents. One day during the week the residents cook the meal. They are involved in menu planning and some do the shopping. They have free access to the kitchen to make snacks and drinks. Residents are not required to go to bed or get up at set times in the morning and they can choose whom they share a room with. Most residents manage their own finances. Some residents have a daily allocation of their money and they are all in receipt of appropriate benefits. There is a policy on financial management in place. Residents are encouraged to buy their own clothes from the local shops and they have certain washing days where they have access to the utility room. Residents use the services in the community which are within walking distance and there is access to public transport. It is planned to have a variety of information on treatment and therapies for the residents. They all have the right to vote and there is a complaints procedure in place. There is a monthly community meeting between the residents and staff.

RECORDS

At the time of the inspection the records were being up-dated. There was evidence that there are multidisciplinary care plans being developed. Clinical files were not kept on the premises.

ENVIRONMENT

This is a two-storey house in very good condition that has recently been décorated and adapted for the use as a residence. The furniture was comfortable and there was emphasis on safety, privacy and dignity. The residence consisted of a number of double rooms that were en-suite, a lounge area, kitchen, dining room, sufficient bathrooms and toilets and a nursing office. There is a utility room at the back of the house.

AREA 6

266 NORTH CIRCULAR ROAD

Date of inspection: *9th November 2005*

Number of beds: *17 integrated*

DESCRIPTION

This is a 17-bed community residence with 24-hour nursing staff supervision. The residence opened 12 years ago. On the day of inspection, there were six male residents and eleven female residents.

REFERRAL

Referral to the residence is from the rehabilitation team at St. Brendan's Hospital. It was reported that it is a fairly static population. Any new referrals are identified by a consultant psychiatrist at a team meeting and an assessment is carried out, including a risk assessment. The mechanism for admission is a gradual introduction to the residence, although it was reported that recently there have been admissions without any of this process taking place due to pressure on beds, shortages of staff and closure of wards in St. Brendan's.

PROCESS OF ADMISSION

There is an admission policy in existence. The only exclusion criterion is a recent history of violence. The main reason for admission is to participate in a rehabilitation programme and to integrate people in the community. It was reported that there is little movement of the resident group. More recently, people have been moved from St. Brendan's due to pressure on beds and as an alternative to acute admission. On admission a psychiatric assessment is undertaken and also a physical examination. Each of the residents is registered with a GP. It is a team decision to admit, when the admission process is followed. The resident is involved in the admission

and the initial treatment plan as much as possible. No formal assessment tool is used. The residence staff encourage contact with family. The initial treatment plan is stored in the nursing and medical notes. There is no key worker system as staff stated that central rostering makes it impossible.

CARE PLAN

Care plans are nurse led and there is minimal involvement of occupational therapy and social work. There is no access to clinical psychology. Nursing care plans are needs identified and have goals and objectives identified. Care plans are reviewed every six months. It was reported that few people are discharged from the residence.

NURSING PROCESS

It was reported that the nursing model used is an individual service plan that was introduced some time ago. It was described as appropriate to the needs of the residents and is implemented by the nursing staff. However this has caused problems due to the fact that a central roster means there is no consistent staffing within the unit and many of the reviews are undertaken by the CNM2.

REHABILITATION TEAM

There is no access to clinical psychology. The nurses reported that there is minimal access to social work and a referral system to occupational therapy. There is access to a rehabilitation consultant psychiatrist and the sector team consultant psychiatrist. The consultant psychiatrists hold regular clinics every four weeks and write interventions in the notes which are then returned to the residence.

INVOLVEMENT IN REHABILITATION PROGRAMMES

There is minimal evidence of needs-based individual programmes. The residents are not involved in programmes to move them to lower levels of support. Some attend day services off site. The service policies were available and were last updated in 2002. A residence profile is currently being prepared.

CLINICAL RISK MANAGEMENT

There were no formal risk assessments undertaken. Any serious incidents are recorded on appropriate forms and sent to the Assistant Director of Nursing and there is some feedback.

UNIT MANAGEMENT

There are no temporary transfers from the unit due to bed pressures, although when there is a vacancy patients from St. Brendan's are admitted on a temporary basis. The nursing staff in the residence are qualified and student nurses. During the day there is a CNM2, a staff nurse and one care staff on duty who work a 'day on, day off' rota system. At night there is one staff nurse and a care staff. The staff are rostered using a central rostering system and there is one full time domestic staff member and one part-time. Maintenance is carried out by the St. Brendan's maintenance team and it is described as an unsatisfactory arrangement.

HOUSE RULES

There are house rules regarding smoking. Visiting times are flexible. The residents do not have keys to the front door or their bedroom doors. Residents are allowed to leave unsupervised, but they are asked to check in with staff when they leave and when they return. They are not required to be out during the day. Meals are prepared on site by the household staff. The residents are involved in shopping and menu planning. There is minimal access to the kitchen to make drinks and snacks. Residents are not required to go to bed at set times or get up at set times in the morning. There is only one single room and the residents choose with whom they share a room. Some of the residents manage their own finances and the others have their money collected by staff. There is a policy on financial management of residents' money and residents have access to their own money as required. Residents are encouraged to buy clothes in their local shops and have rostered access to the utility room. They access services in the community unaided, for example, shops, pubs and the local church. The facilities are within walking distance and there is access to public transport.

SERVICE USER INVOLVEMENT

There does not appear to be any information on treatment or therapies available although there is a profile of the unit. The residents have the opportunity to vote. There is a complaints procedure. The residents' opinions are sought for specific issues. At the time of inspection (in the early afternoon) there were six or seven residents sitting smoking in the smoking room.

RECORDS

The clinical files were in good condition and showed evidence of regular reviews and were neat and legible. The medication sheets were satisfactory. All nursing care plans were up to date and showed evidence of regular reviews.

ENVIRONMENT

The residence was very run down and dull. Paint was peeling in some areas. The whole residence smelt strongly of cigarette smoke from the smoking room, which was inside the front door. The smoke extractor fan was not running at the time of inspection and six residents were smoking in the room. There was a sitting room that had poor furniture and was very gloomy. The dining room was also grim and poorly décorated. The kitchen was locked at the time of the inspection although it was stated that residents have free access to the kitchen. The bathroom floor was in poor condition and the shower was dirty. The bedrooms were mostly double rooms and most had personal effects. The nursing office was very small.

STAFF TRAINING

There is some training available on a mandatory basis. It was reported that the CNM2 is the only consistent member of staff due to the central rostering.

ADELPHI HOUSE, NORTH CIRCULAR ROAD

Date of inspection: *9th November 2005*

Number of beds: *15 integrated*

DESCRIPTION

Adelphi House is a 15-bed residence on North Circular Road. It was originally opened in the 1980s. There are no respite beds and no crisis admissions. The age range of residents is from 45 to 75 years. There have been two discharges and two admissions in the past year. The main focus in the residence is continuing care high support of patients.

REFERRAL / PROCESS OF ADMISSION

There are few admissions as there are long-term residents in the residence. Most admissions to the residence come from St. Brendan's Hospital. Admissions also come from the admission unit and other residences in the service. All residents have a physical and mental health assessment prior to admission to the service. Prospective residents visit the residence for a nursing assessment and to view the residence.

CARE PLAN

The care plan is based on the Orem nursing model. However it is felt by staff that this is not appropriate to the needs of the residents or for active rehabilitation. Care plans are reviewed weekly.

NURSING PROCESS

There are two nursing staff on duty during the day and one nurse and one care assistant on duty at night. There is very little continuity of either nursing staff or household staff. Despite this, there is a primary nurse system in operation. It was reported that the two CNM2 posts are assigned long term and a core of 24 staff nurses rotate through this and the other three high support residences in the area.

North Dublin

REHABILITATION TEAM

There is no rehabilitation team in the service. The team meeting takes place weekly at the sector headquarters and nursing staff from the residence attend. The multidisciplinary team consists of consultant psychiatrist, nursing staff in the community, day centre and day hospital and an occupational therapist. There is no psychologist or social worker on the team.

INVOLVEMENT IN REHABILITATION PROGRAMMES

Residents are involved in a number of different activities. These include attendance at a workshop where piece work is done, a training centre, day centre and day hospital. A small number of residents remain in the residence during the day and do chores. There is no rehabilitation programme involving shopping for meals, preparing and cooking food, buying own clothes in shops, responsibility for household chores, self-medication or personal laundry.

UNIT MANAGEMENT

There are two residents who are ready for discharge to lower levels of supervision. There are two household staff on duty. Personal laundry is done by the nursing staff. All meals are prepared by staff in the residence. There is little input from the residents into shopping and preparation of meals although they have input into the choice of menus. The residents are not allowed free access to the kitchen.

HOUSE RULES

There are house rules preventing smoking in the residence. There is no rota of chores within the residence apart from keeping their own areas clean. Bedtimes are mostly flexible although residents are expected to be in bed by midnight. Some residents have their own front door key. The residents are free to leave the residence but are encouraged to inform staff when they leave. Residents collect their own allowances but some require help in budgeting. Some residents buy their own clothes but a retailer brings clothes to the residence where residents can chose items from a selection. Residents do not use the laundry room. Most residents use the local shops and coffee shops.

SERVICE USER INVOLVEMENT

Community meetings with staff and residents have recently commenced and minutes are taken of these meetings. Leaflets are available about the service. There is a complaints procedure that is available for residents.

RECORDS

Clinical files were kept in the sector headquarters. Medication sheets were satisfactory. Nursing care plans were up to date and service policies were available.

ENVIRONMENT

Areas of the residence were in need of decoration and new furniture. There is a nursing office which was large but had little storage space. The main shower was on the first floor and was very small. A shower door was required and the extractor fan was broken. The bedrooms were either double or triple rooms. Some rooms had very few personal effects and were quite bare. There were three toilets in the residence. A previous smoking room had been converted into a games room and this was in need of redecorating. There was access to a very pleasant garden. There were two sitting rooms which had institutional furniture and lacked a homely atmosphere. There was a large basement.

ST. ELIZABETH'S COURT, NORTH CIRCULAR ROAD

Date of inspection: *9th November 2005*

Number of beds: *30 integrated*

DESCRIPTION

St. Elizabeth's Court is a large building on North Circular Road. The age range of residents is from 44 to 90 years. It offers continuing care to 30 residents in a nursing home type of environment. It opened in 2001, prior to that it consisted of self-catering bed-sits, owned by the local authority.

REFERRAL / PROCESS OF ADMISSION

There are six consultants admitting to the residence. Referrals are made to the consultant psychiatrist with managerial responsibility for the residence and residents are admitted on a trial basis. All admission procedures are carried out prior to admission. Referrals come from St. Brendan's Hospital and from other residences. There are occasional respite or crisis admissions as an alternative to admission. In 2004 there were 16 admissions and 14 discharges from the residence. No discharges were to lower supervised accommodation.

CARE PLAN

There are nursing care plans based on the Orem model of nursing care. Staff feel that this is appropriate to the resident group. The care plans are reviewed monthly with a comprehensive overall review every six months. There is an informal discharge plan.

NURSING PROCESS

There is a primary nurse system in operation but there are difficulties with continuity of staffing due to central rostering. There are two nursing staff and two care assistants on duty during the day and one staff nurse and one care staff on duty at night.

REHABILITATION TEAM

There is no rehabilitation team in the service. There are no formal team meetings but the NCHD calls to the residence on a regular basis. Residents attend outpatient appointments. There is an occupational therapist with input to the residence for two sessions a week. There is no psychology or social work input to the residence.

INVOLVEMENT IN REHABILITATION PROGRAMMES

Some residents attend a variety of activities, including day centres and work shops as well as the twice weekly occupational therapy. There are also outings from the unit on a regular basis.

UNIT MANAGEMENT

There are occasional patients sleeping in the unit due to bed shortages in other parts of the service. There are meetings with the Assistant Director of Nursing and residence nursing staff. There are two household staff and a chef in the residence. Generic policies are available.

HOUSE RULES

There are house rules regarding smoking, alcohol and drugs. Visiting times are open Residents do not have their own keys. There are no set bedtimes. Residents can come and go as they wish. Efforts are made to accommodate residents' choices in sharing bedrooms. Residents collect their own allowances and have their own post office or bank accounts. Residents' cash is kept in the nurses' office and residents withdraw their money as desired. Residents buy their own clothes but may be accompanied by staff if necessary. A number of residents are well integrated into the local community, attending church services, local bingo and community groups. Many use the local bus service.

SERVICE USER INVOLVEMENT

There are no community meetings with residents and staff. Residents do not participate in the shopping for food, preparation and cooking meals. They have access to the kitchen. There are information leaflets available about the service. There is a complaints procedure available.

RECORDS

The records had regular reviews by the medical staff and a comprehensive care planning process implemented by nursing staff. It was reported that the central rostering process makes it difficult to implement a key worker system due to lack of continuity of care. It was reported that the two CNM2 posts are assigned long term and a core of 24 staff nurses rotate through this and the other three high support residences in the area.

There was evidence of resident involvement in the care plans.

ENVIRONMENT

The residence was on two floors, combining sleeping accommodation, lounge areas, dining room and industrial kitchen, occupational therapy area, and sufficient toilets and bathrooms. It was clean and recently décorated. There was disabled access but it was reported that accessing the occupational therapy area and some of the bathrooms was difficult, and that it was impossible for any resident in a wheelchair to attend the occupational therapy area as it was upstairs and there was no lift in place.

ARD NA GRÉINE RESIDENCE

Date of inspection: *9th November 2005*

Number of beds: *10 integrated*

DESCRIPTION

This is a 10-bed community residence with 24-hour nursing staff supervision. The residence is situated on the North Circular Road in Dublin and became a high support residence in 1999. On the day of inspection, there were three male residents and seven female residents.

REFERRAL

Two sectors, Blanchardstown East and West, are the main source of referral. Referrals are also received from the acute ward in Connolly Hospital and from medium and lower support residences. The process of referral is through the consultant psychiatrist. Referrals are assessed in the hospital and a gradual introduction process is facilitated to a planned discharge to the residence. This usually takes between two and four weeks.

PROCESS OF ADMISSION

There is a general policy regarding admission to the residence. The only exclusion criterion is a recent history of violence or aggression. The main reason for admission is for a rehabilitation programme. There is an active programme in place. It was reported that one of the sectors has a more active programme with an emphasis on moving people to lower supported accommodation, or into independent living. The residence is sometimes used as an alternative to an acute admission in a bed crisis. It was reported that there is a nursing assessment on admission. The resident is orientated to the unit and nursing staff use the Orem model of nursing. Each resident is registered with a GP. Some of the GPs are in Blanchardstown, which causes some logistical problems. The consultant psychiatrist makes the decision to admit to the residence. Staff try to communicate with the residents as much as possible regarding their treatment plan. Residents sign their initial treatment plan and the residence has introduced a new form devised from the Tidal nursing model. Family participation is encouraged and a number of the residents go home on weekend leave. The residents are reviewed by a consultant psychiatrist from each of the sectors in different ways. If from the East team, they attend an outpatient clinic on a monthly basis but there is no structured feedback mechanism for the residence staff. The West team visit the residence on a monthly basis and feed back directly to the residence staff. The initial treatment plan is stored in the nursing notes. There are no medical notes in the residence. It

was reported that there is a key worker system but this is made difficult by the central rostering system.

CARE PLAN

Care plans are nurse led and currently based on Orem's model of nursing. There is a review of the care plans taking place. The care plans are needs identified but only involve medical and nursing staff. Goals and objectives are identified and care plans are reviewed depending on need. It was reported that a number of the residents have been in the residence on a long-term basis. It is hoped that there will be more throughput within the residence and that residents will be involved in a more active rehabilitation programme. Currently there is one resident awaiting a lower level of supported accommodation.

REHABILITATION TEAM

There is no access to a psychologist and there is minimal access to an occupational therapist and social worker. There is access to a behavioural therapist. There are three consultant psychiatrists who have admitting rights to the residence and they review patients monthly as described earlier.

INVOLVEMENT IN REHABILITATION PROGRAMMES

All residents have an individual programme. On the day of inspection, all the residents were participating in their programme. Some of the residents are involved in programmes to move to lower levels of support and others are described as long stay. Residents attend day services off site but there is no structured format for feedback.

CLINICAL RISK MANAGEMENT

Policies on clinical risk management, both local and HSE are available on the unit. There are no individual risk assessments in the residents' nursing notes. Serious incidents are recorded on appropriate forms and sent to the Assistant Director of Nursing.

UNIT MANAGEMENT

Residents are not transferred elsewhere due to bed pressures but requests are made to the residence staff to accommodate patients from the acute unit if there is a bed crisis. If a resident becomes unwell while in the residence they may be transferred to the acute unit in Connolly Hospital. The staff in the residence are qualified nurses and there are also student nurses. During the day there are two staff on duty as well as a student and at night there is one staff nurse and a care staff. Staff are rostered from a central roster. There are two household staff on duty. The ethos of the residence is to promote rehabilitation and continuing care high support. There is a formal process of induction for residents, staff and students. There are appropriate policies and procedures present. There is no uniform, but a dress code is in operation. The waiting list for the residence is managed in the sector teams. Maintenance is provided by St. Brendan's maintenance staff but this can be difficult to access.

HOUSE RULES

There are house rules regarding smoking and respecting other people's space. Visiting times are flexible. Residents do not have a front door key and cannot lock their bedroom doors. They are allowed to leave the residence unsupervised and are asked to inform staff where they are going and what time they will return. They are not required to be out during the day. Meals are prepared by the household staff on site. Residents are involved in menu planning and shopping and they have free access to the kitchen to make drinks and snacks. They are not required to go to bed at set times but they are asked to be up in the morning to attend to their programme. Residents manage their own finances and are encouraged to have savings accounts. There is a policy overseeing the financial management of residents' money and they have independent access to their money as required. Residents' access services in the community unaided and most of these are within walking distance.

North Dublin

SERVICE USER INVOLVEMENT

There is information on treatment and therapies available and all the residents have the right to vote. There is a complaints procedure and complaints are followed up appropriately. There is a community meeting held on a regular basis within the residence.

RECORDS

The medical files were all stored in the hospital so they could not be reviewed on this inspection. The nursing files had relevant care plans and were up to date and as described earlier the nursing staff are moving from the Orem nursing model to the Tidal model. The medication card indexes were all signed and legible. There was one person on a self-medication programme.

ENVIRONMENT

There is no regular maintenance programme in place. Maintenance is provided by St. Brendan's Hospital, which can be difficult to access. The hygiene of the residence was good. The décor was of a reasonable standard. The residence consisted of a range of three-bed rooms which were cramped, a double room and single rooms. There were two lounges furnished to a high standard, kitchen, dining room, toilets, bathrooms and a nice garden area.

STAFF TRAINING

There is an in service training programme and support is given to the staff for the attendance of long courses.

ST. BRENDAN'S HOSPITAL

WARD 8A

Date of inspection: *14 November 2005*

Number of beds: *13 male*

DESCRIPTION

Ward 8A is a locked secure ward in St. Brendan's Hospital. There were 15 patients on the day of inspection and three patients were sleeping in seclusion rooms due to shortage of beds. Ten patients were detained and three were long-stay patients. The ward is on the ground floor and there is access to an outside space.

REFERRAL

All referrals to the unit are through the consultant psychiatrist. Referrals come from all mental health services in the Northern area and also from other HSE areas.

PROCESS OF ADMISSION

Most admissions are on Temporary status. All admissions are discussed with the consultant psychiatrist. There is an admission policy. Children under 16 years are not admitted to the ward. Admissions are assessed by the NCHD and are seen within 24 hours by the consultant psychiatrist. It was stated that patients are initially nursed in night clothes for about a week following admission.

CARE PLAN

There is a nursing care planning based on the Orem model of nursing care. It was felt by staff that this was not fully appropriate to the needs of the patient group. Each care plan is regularly up-dated and reviewed every month. There is no formal multidisciplinary discharge plan.

North Dublin

NURSING PROCESS

There are five nursing staff on duty during the day and three nursing staff on duty at night. There are two levels of observation on the ward: general observation and special (one-to-one) observation. There is no key worker or primary nurse system on the ward. There is a lack of continuity of nursing staff and difficulties in maintaining staffing levels.

ACCESS TO THERAPY

There is limited psychologist input, sometimes it is necessary to access private psychology for assessments. There is an occupational therapist but no social worker. Access to addiction counsellors is through the outpatient service following discharge. The consultant psychiatrist and NCHD attend the ward on most days. There is also access to a physician who attends the hospital weekly. There are weekly team meetings with the consultant psychiatrist, nursing staff and occupational therapist.

ACCESS TO THERAPEUTIC PROGRAMMES

Currently six patients attend the special care therapy which is situated off the ward. Activities include pool, relaxation, socialisation, painting and word games. The special care therapy unit is currently being renovated. Only one patient is currently attending occupational therapy and there are no occupational therapy sessions or groups on the ward apart from initial assessments. It was stated that there was a waiting list for occupational therapy and that some patients were not well enough to go to the occupational therapy department, which is situated in another building on the grounds. There are no activities available on the ward for patients.

ECT

ECT is not carried out on the ward.

SECLUSION

There is a seclusion policy and the seclusion register was up to date and signed by the consultant psychiatrist. There were three seclusion rooms, one of which was completely padded. On this inspection the padding was clean. This room was small and lacked ventilation. There was no natural light as the window was blocked when the room was occupied.

CLINICAL RISK MANAGEMENT

There were policies available in the ward. Staff are trained in crisis prevention intervention and receive a refresher course once a year. Despite the secure nature of the ward there are no routine formal risk assessments carried out. Serious incidents are reported but there is no formal feedback to ward staff of audits of such incidents.

UNIT MANAGEMENT

There are no short-term temporary transfers due to bed shortages. However, there are frequent internal transfers through the special care area and Ward 3A in accordance with need. The door is always locked. CCTV is used on the ward but there are no notices advertising this. Despite the fact that there were no patients in seclusion at the time of inspection, the CCTV cameras were in operation in these rooms, which were being used by patients as an overflow sleeping facility. There is one kitchen staff and one contract cleaner on the ward. Nursing staff perform phlebotomy. It was stated that it is sometimes difficult to get maintenance. Visiting times are between 1400h to 1600h and 1800h and 2000h but are flexible. Some patients were using communal clothing which is unacceptable.

SERVICE USER INVOLVEMENT

There is a unit profile available for patients and families. There is also a suggestion box. There are no ward meetings between patients and staff. The complaints procedure was available. The Irish Advocacy Network is available to the patients attending the special care therapy.

North Dublin

RECORDS

The patients' names and ID numbers were on all the pages. Clinical files were legible and tidy. Entries had the full names and titles of personnel and were signed and dated. There were psychology reports in the files if patients were seeing a psychologist. There was a treatment plan which contained progress reports. The consultant psychiatrist reviewed the patients on a weekly basis and there were regular reports from the NCHD. The nursing files contained appropriate care plans which were up to date and evaluated.

ENVIRONMENT

The ward is on the ground floor and has access to an enclosed garden. Patients are supervised when in the garden. The ward had recently been repainted. It was very small and cramped for 15 patients. There was one large dormitory divided by waist-high partitions. There were no curtains around the beds and the sleeping arrangement offered no privacy. Each patient had a wardrobe. The walls were bare and along the side of the dormitory there were store rooms and a night nursing station. There was one bathroom and shower. Patients are always observed while in the bath. The toilets had broken seats.

There were two side rooms and one seclusion room in an observation area that could be shut off from the rest of the ward. The hall area had a chair but there was no dedicated toilet or shower. As already stated these rooms were being used by patients due to bed shortages.

The sitting room had adequate chairs and there was a TV. The room was quite bare. There was a smoking room and a visitors' room. The dining room was bare and institutional in appearance.

WARD 8B

Date of inspection: *14th November 2005*

Number of beds: *13 male*

DESCRIPTION

Ward 8B is a 13-bed male locked ward in St. Brendan's Hospital. It currently has one extra patient who is sleeping in an unlocked seclusion room. The age range of patients is from 22 to 63 years. On the day of inspection, there were seven patients on Temporary status, one Person of Unsound Mind (PUM), two Wards of Court and four patients on Voluntary status. The ward is on the first floor and has no access to an outside space.

REFERRAL

Patients are referred to the ward through internal transfers from other wards in the hospital and from other hospitals in the HSE area. All referrals are made from consultant psychiatrist to consultant psychiatrist.

PROCESS OF ADMISSION

Only patients with disturbed behaviour are admitted to the ward and there is an admission policy. No children under 16 years are admitted. There are currently two patients with intellectual disability on the ward. Each admission is assessed within 24 hours by the consultant psychiatrist and an initial treatment documented. Patients are not routinely nursed in their night clothes on admission.

CARE PLAN

There is a nursing care plan which is based on the Orem model of nursing. This is usually reviewed every eight weeks, depending on need. There is no multidisciplinary care planning. The patients leave from the ward is termed "liberty status" and is decided at the weekly team meeting. There is a discharge policy and a written discharge plan.

North Dublin

NURSING PROCESS

There are five nursing staff on duty during the day and three nursing staff on duty at night.

ACCESS TO THERAPY

There is very little psychology input; sometimes it is necessary to access private psychology for assessments. There is an occupational therapist but no social worker. Access to addiction counsellors is through the outpatient service following discharge. The consultant psychiatrist and NCHD attend the ward on most days. There is also access to a physician who attends the hospital weekly. There are weekly team meetings with the consultant psychiatrist, nursing staff and NCHD and all patients are reviewed.

ACCESS TO THERAPEUTIC PROGRAMMES

Patients may attend the special care therapy which is situated away from the ward. Activities in the therapy area include pool, relaxation, socialisation, painting and word games. The special care therapy unit is currently being renovated. There are no occupational therapy sessions or groups on the ward apart from initial assessments. There are no activities available on the ward for patients, but it was reported that patients are regularly brought out to local shops and cafes in the local community.

ECT

There is no ECT administered on this ward.

SECLUSION

There is a seclusion policy and register in place. The seclusion room is currently being used by a patient, which rendered the room unusable for the purpose of seclusion. The patient was not locked in the room at night. The room itself – if used for seclusion – was appropriate. It was clean and well lit, but did not appear to be ventilated and there was no access to a toilet. There was an observation panel in the door. It was reported that on occasions patients placed in seclusion were clothed in refractory clothing. The room is monitored by CCTV.

CLINICAL RISK MANAGEMENT

It was noted that the policies in place in the unit were implemented in 2002 and therefore in need of review. There is an alarm system in operation. There is a policy on patients absconding, the management of violent episodes and searching patients' belongings. Staff were trained in control and restraint techniques which included de-escalation and breakaway techniques. Staff are also encouraged to undertake other mandatory training.

UNIT MANAGEMENT

There are no short-term temporary transfers due to bed shortages but there are frequent internal transfers through the special care area and Ward 3A if necessary. The external door is always locked. CCTV is used on the ward but there are no notices regarding this practice. There is one kitchen staff and one contract cleaner available to the ward. It was stated that it is sometimes difficult to get maintenance. Nursing staff perform phlebotomy when required. Visiting times are usually between 1400h to 1600h and 1800h to 2000h, but are flexible. Communal clothing is sometimes used.

SERVICE USER INVOLVEMENT

There is a unit profile available for patients and families and there is also a suggestion box. There are no ward meetings between patients and staff. The complaints procedure was available. The Irish Advocacy Network is available to the patients attending the special care therapy.

RECORDS

There is a shared file in that all disciplines write in. The patients' names and IDs number were on all pages and the files were legible and tidy. The entries all had the full names and titles of personnel and

were signed and dated. There was no formal risk assessment in any of the charts reviewed. There were no progress reports from any other member of the multidisciplinary team. The treatment plans were medical and nursing. The consultant psychiatrist reviews on a weekly basis and there was regular contact with the NCHD. The nursing care plans were recent and up to date and regularly reviewed. Medication cards were all recently rewritten and were signed, dated and legible. Generic names were used and discontinuation of medication was signed and dated.

ENVIRONMENT

This was a 13-bed ward on the first floor of the hospital. On the day of inspection, there were 14 patients. There is a maintenance programme. There is no disabled access. The unit had recently been décorated. There was an information board that had information on advocacy and the complaints procedure. There were two areas specifically for visitors. There was no access to a garden. The bedroom areas were a mix of two 3-bed areas and one 7-bed area. There was also one patient in the seclusion room. There were no curtains around the beds and it was reported this was necessary for observation. There was wardrobe space for each patient. There was one toilet and bathroom with a shower area. Generally the décor was good. The bathrooms were locked and there were specific bathing times and all patients are supervised by a nurse when using the bath. The equipment in the bathrooms could be updated. There were three toilets in the toilet area, one of which was out of order. It was reported that some of the patients wore communal clothes.

The dining area had space for all patients at one sitting and it was self-service and integrated. Normal crockery and cutlery was used. Special arrangements were made for patients who were disturbed. There was no separate area for exercise or activity. The lounge area had TV, radio and newspapers available. There were no books on the unit. There was an extra room used for music and TV and a smoking lounge with ventilation. The furniture was not of a good standard and the staff reported that they were not consulted with regard to purchasing furniture for the unit. The interview rooms on the unit doubled as visitors' rooms. The nursing station was situated centrally within the unit and there was a night nurse station near the dormitory. The clinical room was situated centrally and had all the necessary medical and cardio-pulmonary resuscitation equipment. The defibrillator was on Ward O. There was limited storage for patients' possession. The seclusion room currently being used as a bedroom was at the end of the dormitory. The walls were clear and smooth and the windows were boarded. The door opened outwards and was padded. The bed was fixed to the floor.

WARD O

Date of inspection: *15th November 2005*

Number of beds: *12 female*

DESCRIPTION

Ward O is a female locked ward in St. Brendan's Hospital. At the time of inspection there were nine patients on Temporary status.

REFERRAL

The source of referral to Ward O is other hospitals in the Dublin area, the Central Mental Hospital, Ward 3B and outpatients. The process of referral is through the consultant psychiatrists' team or consultant psychiatrist on call by prior arrangement.

PROCESS OF ADMISSION

People with a moderate intellectual disability are admitted to the ward only if they have a mental illness and their symptoms cannot be managed in a more open environment. On admission, the patient is assessed by a consultant psychiatrist and a physical examination is undertaken. The consultant psychiatrist decides whether to admit to the unit. A nursing assessment takes place in the assessment unit within the hospital campus. It was reported that staff try to engage with the patient on admission wherever possible and also try to keep in contact with family members. An initial treatment plan is documented in the notes. There is a policy regarding

nursing patients in night clothes and all direct admissions to the unit must wear night clothes. There is general observation and special (one-to-one) observation. It was reported there is a key worker system in place but this is hindered by the central rostering system.

CARE PLAN

The care plans are nurse led. The nursing needs are identified and goals and objectives are set. There is minimal input from a multidisciplinary team. It was reported that the psychologist was on leave. There is no social worker but there is some occupational therapist input. Care plans are reviewed depending on the need of the patient. There is no documented participation by the patient in the care planning system. It was reported as being tried in the past but that patients had limited understanding of the process. Patients are transferred from this unit usually to Ward 3B within the hospital. It was stated that one patient is deprived of possessions such as her radio for bad behaviour but there was no written behavioural programme or any written record of this practice when requested by the Inspectorate.

NURSING PROCESS

The Orem nursing model of care is used on the unit and is described as appropriate to the needs of the patients. It is implemented by a key worker. The only risk assessment carried out is part of the Orem model. There are no formal risk assessment tools.

ACCESS TO THERAPY

There is minimal multidisciplinary team input on the unit, though there is access to a behavioural therapist. There is one consultant psychiatrist who carries out regular reviews. Any medical or surgical consultations are with the Mater Hospital A&E department or outpatients. There is also a visiting hospital physician on a weekly basis, with referrals through the Clinical Director's office.

ACCESS TO THERAPEUTIC PROGRAMMES

Six patients go to special care therapy. Some low key groups are run on the unit.

SECLUSION

There are a total of four rooms that can be used for seclusion. At the time of inspection three rooms were used as single rooms but it was stated that they have been converted into seclusion rooms by removing the bed and putting the mattress on the ground. One of the rooms is a green padded seclusion room which when occupied has no natural daylight, though there is air conditioning. Patients are always put into refractory clothing when in seclusion. It was stated that patients may request seclusion if they feel that they might harm themselves, and that the door may or may not be locked. This is recorded as a reason for seclusion in the seclusion register. The register also shows that seclusion is used for suicidal behaviour within the context of highly disturbed patients.

CLINICAL RISK MANAGEMENT

There are policies in place within the hospital. There is an alarm system in operation. It was reported that staff receive training in control and restraint techniques which include de-escalation and breakaway techniques. There is also mandatory training, cardio-pulmonary resuscitation and manual handling. Serious clinical incidents are recorded in the incident book and sent to nursing administration. There is no formal feedback to the ward. There is little evidence of debriefing after serious incidents and it was reported that support is available from the HSE through Dr. Steeven's Hospital.

UNIT MANAGEMENT

Patients are regularly transferred to other units within the hospital and also returned following treatment to the referring hospital. There are limited activities available on the unit. One patient was allowed unescorted liberty from the unit. Others are escorted. The unit is always locked. CCTV is in operation in the single rooms and seclusion room. During the day there are six nursing staff on duty and three nursing

staff on duty at night. The staff are provided through a central rostering system. There is one household member of staff in the kitchen and the cleaning is provided by a contract cleaner. The dress code is uniform. It was reported that currently five patients are aiming for a discharge and that one patient is waiting for a nursing home placement and another for a service in intellectual disability. Maintenance is provided by the HSE maintenance team and is in high demand at the moment. Visiting times are set as are meal times and snacks and drinks are available between meals.

SERVICE USER INVOLVEMENT

There is information on treatment and therapies available. There is a complaints policy and appropriate follow up of complaints. It was also reported that there is access to an advocacy service.

RECORDS

The clinical files were legible, tidy and up to date. They showed evidence of regular consultant psychiatrist and NCHD review. The medication sheets were up to date and legible. The nursing files were up to date.

ENVIRONMENT

Ward O is in St. Brendan's Hospital. It was a small ward and had access to a pleasant garden. The overall décor was reasonably good. There were 11 beds in one dormitory and this room was also used as a team meeting room. There were no curtains around the beds so there was no privacy for patients. There were individual wardrobes. Patients had their own clothes and toiletries. There was one sitting area with a small smoking room to one side. The sitting area was pleasantly décorated and bright. There was only one bathroom and shower and there are five toilets.

WARD R

Date of inspection: *15 November 2005*

Number of beds: *3 female*

DESCRIPTION

Ward R is a locked female ward in St. Brendan's Hospital. At the time of inspection, the ward that formerly accommodated the Ward R patients was being refurbished and, since April 2005, these patients are in temporary accommodation. On the day of inspection, there were five patients. Two patients had Temporary status and three had Voluntary status. The ward provides continuing care in a locked environment. The age range of patients is 52 to 73 years.

REFERRAL

According to staff, all of the patients are long stay in the hospital and there are no new admissions.

CARE PLAN

There is no system of multidisciplinary care planning in place. The care plans are nurse led. Following an assessment, needs are identified and goals and objectives are set. These are reviewed on a weekly basis. There is no documented participation by the patient in care planning system. Staff reported that one patient may be suitable for a placement in a high support hostel. Three of the patients were discharged in the recent past but all returned to the ward following a breakdown of the placements.

NURSING PROCESS

The Orem model of nursing is in use. There is no key worker system. Continuity is provided by the CNM2, who is on duty every second day. There is no formal risk assessment carried out as part of the Orem model. The levels of observation are general and special (one-to-one). At the time of inspection, one of the patients had special nursing on a full-time basis. Staff wear identification badges and uniforms.

North Dublin

ACCESS TO THERAPY

The consultant psychiatrist visits the ward at least once a week. There is no social work or psychology input into the ward. Referrals can be made to an occupational therapist. If patients require medical or surgical consultations, they are referred to the Mater Hospital by the NCHD. Laboratory and X-ray results can be accessed quickly. Physical examinations are carried out every six months.

ACCESS TO THERAPEUTIC PROGRAMMES

It was reported that there are individual needs-based programmes designed for the patients. Two of the patients attend special care therapy, where they participate in knitting, making cards among other activities. One patient attends the occupational therapy department for art therapy and she is also involved in setting up a library. According to staff, two patients refuse to attend groups or therapeutic activities. A minibus is used for outings at the weekends. All but one of the patients participate in the outings.

SECLUSION

Due to the refurbishment that is taking place, Ward R does not have a seclusion room. Staff reported that, when seclusion had been authorised for patients of Ward R, patients were brought downstairs to Ward O and secluded there. This arrangement is unsatisfactory. The seclusion policy dated from 2002 and was due to be updated in 2004.

CLINICAL RISK MANAGEMENT

There are policies on clinical risk management in place within the hospital. It was reported that staff receive training in control and restraint techniques, which include de-escalation and breakaway techniques. There is also training in cardio-pulmonary resuscitation and manual handling. There is a system for recording and auditing serious clinical incidents. Staff reported that a mechanical restraint device is available on the ward to be used on one of the patients in particular and that, on at least one occasion, this device was used to restrain this patient in the day room in the presence of other patients. Documentation of its use on that occasion could not be located and this was of concern. It was reported, however, that the use of mechanical restraint is always documented in the psychiatric notes and in the nursing notes.

WARD MANAGEMENT

The ward is locked at all times. There are no temporary transfers to other units due to bed shortages. One patient is allowed off the ward unaccompanied. CCTV is not used on the ward and the ward is not used for any other purpose. There is no waiting list for the ward. There are few activities available on the ward but patients have access to TV, newspaper and games. There is central rostering. The ward is staffed during the day by a CNM2 and three staff nurses and by three staff nurses at night. There is one household staff member on duty during the day. An allowance has been made available to Ward R for the purpose of purchasing clothes for each of the patients. There is no process of induction for staff. There is no ward clerk. Phlebotomy services are provided from the hospital. Four of the five patients were on comforts allowance. Meal times are 0900h, 1200h and 1700h. Drinks and snacks are provided at regular times. Patients do not have access to the kitchen. Visiting times are flexible but visits normally occur in the afternoon. No children are allowed on the ward.

SERVICE USER INVOLVEMENT

Information on treatment and therapies and patients' rights is given verbally. There is a complaints policy and a notice to this effect. There is a suggestion box. There is no community meeting and no advocate visits the ward.

RECORDS

The clinical files were integrated on this ward. They were legible, tidy and up to date and showed evidence of regular consultant psychiatrist and NCHD review. They contained treatment plans and progress notes. The titles of those making entries were rarely

used. The medication sheets were up to date and legible but discontinuation of medication was not always signed or dated. A signature bank was available for nursing staff. The nursing notes were up to date. There was no evidence of progress notes from other professionals.

ENVIRONMENT

The patients from Ward R were being accommodated in temporary accommodation in the former special care therapy area while the ward they formerly inhabited was being refurbished. At the time of inspection, patients had been in temporary accommodation for seven months. The area inspected was small and inadequate for the purpose for which it was being used. The area was dark and the décor was not of a high standard. All five patients were being accommodated in one bedroom and this afforded little privacy or space. The day room doubled as a dining room and was located at the centre of the area with all other rooms leading off it. There was a small nursing office, a kitchen, a clinic room, store rooms and toilets and a shower for patients. Patients were given access to an enclosed garden area downstairs. There were no staff facilities except a toilet. There was no computer available for staff or patients.

WARD 3A

Date of inspection: *15th November 2005*

Number of beds: *27 male*

DESCRIPTION

Ward 3A is located in a block in the grounds of St. Brendan's Hospital. It is an open ward, however there is continuous security on the main entrance to the building. On the day of inspection, there were seven patients on Temporary status and one Ward of Court. The ward caters for long-stay patients as well as accepting admissions. Currently there are 22 long-stay patients and five recent admissions on the ward. There have been two recent transfers from Ward 23, which recently closed. The age range of patients is between 31 and 62 years.

REFERRAL

There are seven consultants who admit patients and have clinical responsibility for patients on the ward. Referrals come from the sector community services, the homeless service, the community residences and a number from outside the catchment area. There are also internal transfers to the ward from other wards within the hospital.

PROCESS OF ADMISSION

All admissions to the ward are processed in the assessment unit. Any patient with disturbed behaviour is admitted to the special care wards (Wards 8A and 8B). There are no admissions of children under 16 years. There are occasional admissions for drug or alcohol detoxification if outpatient detoxification is not possible. All admissions are discussed with the consultant psychiatrist who assesses the patient within 24 hours of admission. The initial treatment plan is drawn up by the sector team. All patients are initially nursed in their night clothes following admission.

CARE PLAN

There is no multidisciplinary care planning. There is a nursing care plan that is based on the Orem model of nursing. This is reviewed at least every month, more often for patients who have recently been admitted. There is no formal documented discharge plan.

NURSING PROCESS

There are five nursing staff on duty during the day and two nursing staff at night with input from the nurse in the assessment unit. There is a primary nurse system in operation but this is hampered by the lack of continuity in staffing. There is general observation and special (one-to-one) observation; any patient requiring higher levels of observation is transferred to the special care unit.

ACCESS TO THERAPY

Access to clinical psychology services and occupational therapy is by referral. It was reported

that there is no attendance by a psychologist or social worker to the team meetings, but occupational therapists attend on occasions. There are weekly team meetings attended by the medical and nursing staff. Patients are reviewed at least weekly by the consultant psychiatrists and often daily by the NCHDs. A physician attends the hospital weekly for medical consultations.

ACCESS TO THERAPEUTIC PROGRAMMES

Three patients currently attend occupational therapy. It was reported that there is a waiting list for occupational therapy. There is an activation nurse assigned to the ward but this nurse is often called away due to staff shortages elsewhere in the hospital. Ward activities include exercise, painting and crosswords.

ECT

ECT has been discontinued in the hospital recently. There is an ECT suite but the waiting area is currently used to store miscellaneous equipment and the recovery room is used as an activation room.

SECLUSION

There is no seclusion on this ward.

CLINICAL RISK MANAGEMENT

All policies were available and were last reviewed in 2002. They are currently being reviewed. Mechanical restraint is not carried out on the ward. All staff have trained in crisis prevention intervention; manual handling and cardio-pulmonary resuscitation training are currently being offered. Serious incidents are reported to senior management. However there is no formal feedback to the ward regarding audits of serious incidents.

WARD MANAGEMENT

Patients are regularly transferred in and out of the ward because of bed shortages elsewhere in the hospital. There is no bed management system, despite a waiting list for beds and frequent movement of patients around the hospital and to hostels to make room for new admissions. Dormitories are locked for part of the day to prevent patients lying on the bed. CCTV is only used for external security. There are two household staff on duty during the day. Phlebotomy is provided by nursing staff. Some long-stay patients did not have personalised clothing, which is unacceptable.

SERVICE USER INVOLVEMENT

There is an abundance of information leaflets and notices available for patients on the ward. The complaints procedure is available. There is also a recently introduced suggestion box. There are no ward meetings between staff and patients. The Irish Advocacy Network is available to patients.

RECORDS

The clinical files were tidy, manageable and legible. There was evidence of regular review by consultant psychiatrist and NCHDs. Each entry contained a treatment plan. The nursing files and care plans were up to date and showed evidence of regular reviews. The medicine sheets were satisfactory.

ENVIRONMENT

The ward was an L-shaped building with long corridors that were gloomy and had poor ventilation. The entire ward required re-decorating. There were new windows and a new heating system since the previous inspection. There was one 8-bed dormitory and two 6-bed dormitories. The 8-bed dormitory was over-crowded, with little space between the beds. All dormitories had curtains around the beds and individual wardrobes. Efforts had been made to brighten them with coloured quilts. At the time of the inspection, two patients were locked into the dormitories at their own request to prevent other patients disturbing them while they were resting. All the toilets required toilet seats. The sluice room was combined with a wash room for the patients. The TV room needed new chairs and redecorating and the

patients complained that the TV and the radio were broken. There was a football table in the TV room. The smoking room needed re-decorating. There was a consulting room, a clinical room and a large nurses' office. The bathroom was too small and required a new bath. There was a hairdresser's room on the ward which served the whole hospital. The dining room was quite pleasant but needed painting. There was a decking area and gazebo at one end of the building.

WARD 3B

Date of inspection: *15th November 2005*

Number of beds: *27 female*

DESCRIPTION

This is a female admission ward in St. Brendan's Hospital and is described as an open ward. On the day of inspection, there were three patients on Temporary status and one Ward of Court. Eight consultant psychiatrists, five from St. Brendan's and three from the Finglas and Cabra catchment area, have admitting rights to the ward.

REFERRAL

All admissions are from the assessment unit on the campus of St. Brendan's. The source of referral is the Finglas and Cabra Sectors, the homeless team and self-referrals. All admissions are transferred from the assessment unit and orientated to the ward.

PROCESS OF ADMISSION

Nobody under the age of 16 is admitted to the ward. Currently there is one 17-year-old patient. On occasion, people with a moderate intellectual disability are admitted. People are frequently admitted for detoxification. A full psychiatric assessment is undertaken at the assessment unit, as well as a physical examination, and a collateral history is obtained. The person making the decision to admit the patient is an NCHD in conjunction with the consultant psychiatrist and the CNM2. Staff attempt to keep the patient informed of the admission process and also include family members.

It was reported that the consultant psychiatrist usually reviews the patient within 24 hours of admission. All new admissions are usually nursed in their night clothes for the first 72 hours – it was reported that there is an open door policy but there was concern if new patients were in a position to leave the ward. There is a main observation area within the ward. Some patients may be placed on special (one-to-one) observation. It was reported that they are attempting to implement a key worker system but due to the central roster system continuity is hindered. The CNM2 and CNM1s are regular staff.

CARE PLAN

Care plans are nurse led and are stored in a separate file. Nursing needs are determined and goals and objectives are identified. There is access to one psychologist and it was reported that patients can access occupational therapy and the special care therapy unit. It was also reported that social worker input was minimal. Care plans are reviewed depending on the needs of the patient. On occasions patients are discharged early due to pressure on beds. The patients' GP and family are informed of the discharge but not the community team. It was also reported that community teams tend not to keep in contact with the ward.

NURSING PROCESS

The Orem nursing model is in use on the ward and is described as appropriate to the needs of the patients. There is a minimal risk assessment undertaken as part of the Orem's model. There is no formal risk assessment tool.

ACCESS TO THERAPY

There is access to a psychologist and some patients access occupational therapy by referral, for example VEC sessions, pottery, drama and music. There is an activity room within the ward. An activities nurse facilitates sessions but is not replaced when not on duty or undertaking training. There is minimal social worker input. There is limited availability of an addiction counsellor. Frequency of review by the eight consultant psychiatrists who have admitting rights to the ward varies.

North Dublin

ACCESS TO THERAPEUTIC PROGRAMMES

There is evidence of a needs-based group therapy which is varied. Most of the patients at some point are referred to occupational therapy which carries out an assessment and provide a needs based programme.

ECT

It was reported that ECT has not been used for the last three years.

SECLUSION

There are no seclusion facilities within the ward.

CLINICAL RISK MANAGEMENT

There is an alarm system in operation although it was reported as currently not working. There is a hospital policy folder present on the ward. It was reported that there is minimal physical restraint used on the ward and if patients became unmanageable they are transferred to either Ward O or Ward R in special care. Staff are trained in control and restraint techniques which includes de-escalation and breakaway techniques. They also receive mandatory training, but it was reported that attending long courses can be problematic. There is a report book for recording serious clinical incidents. It was reported that there is minimal feedback regarding incidents. Any debriefing after a serious incident is initiated by the CNM2 on the ward.

WARD MANAGEMENT

It was reported that there is low morale currently on the ward due to the uncertainty of the future of the hospital. The staff requested that a structured plan be put in place with regular feedback given to staff. It was reported that patients are seldom transferred on a temporary basis to other units. There are activities available on the ward including arts, crafts and games. The patients are allowed off the ward once their mental state permits. The skill mix within the ward is qualified nurses. On duty during the day are one CNM1, a CNM2, four staff nurses and a therapy nurse, when available. At night there are three staff nurses. Staff are provided to the ward via a central rostering system. There are two household staff. There is no ward clerk though this was deemed to be needed. It was reported that five patients could be moved on to hostel placements or nursing home placements if places were available. Maintenance is provided by the hospital maintenance staff and it was reported that it can be difficult to avail of this service. Visiting times are set, as are meal times. There are snacks and drinks available between meals.

SERVICE USER INVOLVEMENT

Information on treatment and therapies is available along with information on patients' rights. There is a complaints procedure and complaints are followed up appropriately. There is a weekly community meeting and there was access to advocacy. There is also a suggestion box on the ward.

RECORDS

The clinical files inspected were tidy, manageable and legible. There was written evidence of regular review by consultant psychiatrist and NCHDs and each entry contained a treatment plan. The nursing files and care plans were up to date and showed evidence of regular reviews. The medication sheets were satisfactory.

ENVIRONMENT

This is a 27-bed acute admission ward for females situated on the first floor. There did not appear to be a regular maintenance programme in place and generally some of the facilities on the ward need to be improved. It was also reported that security is an issue for the unit. There is a porter on duty between 0900h and 1700h but there is no evening or weekend cover. Security is provided at the main gate 24 hrs. The overall décor of the ward was poor and needed upgrading. There was a separate visitors' area and access to the grounds of the hospital. All admissions were seen in the assessment unit prior to

admission to the ward. It was reported that the ward has the capacity for 32 beds but there are currently 27 patients. The dormitories were a mix of one 5-bed room, three 4-bed rooms, and a 12-bed observation area. Each of the bed areas had curtains around them and there was wardrobe space. All of the toilet and bathroom areas needed redecoration and modernisation. The décor was poor and there was little privacy. One of the shower rooms had been subject to repair for the last two weeks and needed ongoing work, but on the day of inspection work had ceased. There was also only one bathroom for 27 people on the day of inspection. The dining area had space for all patients at one sitting and it was reported that the CNM2 was informed that new furniture would be ordered for the dining room to replace the old furniture but this has not been done. All food was prepared in the main kitchen and sent up to the ward. There was a kitchen on the ward and this needed renovating.

There was a separate exercise and activity area. The programme was facilitated by the therapy nurse who also is a manual handling trainer and is not replaced when undertaking training. There was also a kitchen in this facility. There were two lounge areas, one smoking and one non-smoking. This was an innovation since last year's inspection. It was noted due to the secondary glazing window it was hard to keep clean. There were two interview rooms on the ward. There were also two rooms for the use of doctors that were not used and it was suggested that one room could be used as a training resource, but currently this request has been denied. The nurses' station was situated centrally within the ward. It provided confidentiality, and was large, with space for report writing, it was accessible and had a phone system. There was no IT system. The clinical room had all the appropriate equipment, cardio-pulmonary resuscitation equipment and a defibrillator was situated on Ward 3A. There was limited storage for patients' possessions. Money was stored in a safe in the clinic room. There was adequate storage for medication and previously there had been a number of patients on methadone.

THE WILLOWS

Date of inspection: *15th November 2005*

Number of beds: *12 male*

DESCRIPTION

The Willows is a locked male ward in the grounds of St. Brendan's Hospital. On the day of inspection, there were 12 patients, two with Temporary status and 10 with Voluntary status. There is one consultant-led team with admitting rights to the ward. The ward provides continuing care to long-stay patients and acute care to a small number of patients from time to time. The age range of patients is 45 to 72 years.

REFERRAL

The majority of patients are long-stay patients in the hospital. There are some transfers from Ward 3A and occasionally there are direct admissions.

PROCESS OF ADMISSION

There is an admission policy that is generic to the hospital. There are few admissions to the ward. The consultant psychiatrist makes the decision to admit. If there is a vacancy on the ward, staff may be asked to take a transfer from another unit or to receive a direct admission if there is pressure on beds within the hospital. Any new admission is assessed by the NCHD and nursing staff communicate with patients regarding their initial treatment plans and introduce them to the ward.

CARE PLAN

There is no system of multidisciplinary care planning in place. The care plans are nurse led. Following as assessment, needs are identified and goals and objectives are set. These are reviewed on a monthly basis. There is no documented participation by the patient in care planning system. One patient was recently transferred to a nursing home.

North Dublin

NURSING PROCESS

The Orem/Human Needs model of nursing is in use. There is no key worker system. Risk assessment is carried out as part of the Orem model. Staff wear identification badges. The dress code is smart casual.

ACCESS TO THERAPY

An occupational therapist visits the ward weekly to do reminiscence therapy. There is also input from the occupational therapy department in the garden project on the ward. There is no social worker or psychologist input into the ward. The consultant psychiatrist visits the ward at least once a week. An NCHD is assigned to the ward and reviews the patients monthly. Medical or surgical consultations are provided in the Mater Hospital.

ACCESS TO THERAPEUTIC PROGRAMMES

Six patients leave the ward daily to attend therapeutic activities. It was reported that there is a full occupational therapy assessment carried out on all patients attending the occupational therapy department. Sessions include VEC sessional drama, music and dance. Apart from a reminiscence group once a week, there is no therapeutic activity for the six patients who remain on the ward.

SECLUSION

There is no seclusion room and no patients are secluded on this ward.

CLINICAL RISK MANAGEMENT

There are policies on clinical risk management in place within the hospital. It was reported that staff receive training in control and restraint techniques, including de-escalation and breakaway techniques. There is also training in cardio-pulmonary resuscitation and manual handling. There is a system for recording and auditing serious clinical incidents. No risk assessments are carried out on direct admissions to this ward or on patients who are transferred here.

WARD MANAGEMENT

The ward is locked at all times. There are temporary transfers to other units due to bed shortages. One patient was transferred twice within three weeks of his admission to The Willows. Staff reported that the bed of one patient, who was missing from the ward, was filled in his absence. There are few activities available on the ward. Six patients have permission to leave the ward unaccompanied. There is central rostering. The ward is staffed by a CNM2, one staff nurse and two care staff during the day and by two staff nurses at night. There is one household staff member on duty in the daytime and the cleaning is done by a contract cleaner. Clothing is issued from central stores and, according to staff, since there is no individualised clothing or marking of clothes, patients can end up wearing each other's clothes. Only one patient had his own bank account. Six of the patients were on comforts allowance and staff reported that one patient received no money. Meal times are 0845h, 1200h and 1645h. Drinks and snacks are provided at regular times. It was reported that cold teas were provided for patients every weekend and on bank holidays. Patients are not allowed into the kitchen.

SERVICE USER INVOLVEMENT

Information on treatment and therapies is given verbally. There is a complaints policy and a suggestion box and staff reported that there is access to an advocacy service.

RECORDS

The clinical files were integrated on this ward. They were legible, tidy and up to date and showed evidence of regular consultant psychiatrist and NCHD review. The titles of those making entries were rarely used. The medication sheets were up to date and legible but discontinuation of medication was not always signed or dated. A signature bank was available for nursing staff. The nursing files were up to date.

ENVIRONMENT

The ward had been painted during the past year but it needs new floor coverings. There was a nursing office, a day room that doubled as a dining room, a kitchen, and a smoking room. Patients had access to a small enclosed garden. Accommodation was provided in one large dormitory, which offered very little privacy to patients. There were two toilets and one bathroom but no shower. There did not seem to be a maintenance programme in place. Lino in one of the rooms needed to be replaced. One of the machines in the kitchen leaked water into the day room, which had to be mopped on a regular basis. The lock on the door from the dormitory to the grounds needed to be changed so that it can be opened by a pass key.

DANESWOOD RESIDENCE, BALLYMUN ROAD

Date of inspection: *16th November 2005*

Number of beds: *12 integrated*

DESCRIPTION

Daneswood House is a large residence owned by the HSE in Glasnevin in Dublin. It has 14 beds, two of which are respite beds. The age range of residents is from 21 to 71 years and the length of stay varies between long-stay and a few weeks. The role of the residence is in the process of changing from continuing care high support to rehabilitation and this is evidenced by the introduction of needs-based assessments, new care planning usage and multidisciplinary input to the residence.

REFERRAL

Referrals are from the in-patient services and community services. Referrals are discussed at the team meetings and all admissions are planned.

PROCESS OF ADMISSION

The residents are assessed prior to admission to the residence by the NCHD and consultant psychiatrist. The nursing staff from the residence also meet with the resident prior to admission, and the resident also visits the residence. The patients' clinical files are retained in the hospital and do not follow the resident.

CARE PLAN

A new care plan is currently being developed based on the Functional Analysis of Care Environment (FACE) assessment. This is intended to be a multidisciplinary care plan with regular reviews. There is no formal risk assessment.

NURSING PROCESS

There are two nursing staff on duty during the day and one nursing staff and one care assistant at night. There is a lack of continuity of staffing that will impact on the proposed intensive rehabilitation programmes in the residence and on key worker and primary nurse systems. It was reported that the two CNM2 posts are assigned long term and a core of 24 staff nurses rotate through this and the other three high support residences in the area.

REHABILITATION TEAM

There is no dedicated rehabilitation team. There are weekly team meetings in the sector headquarters but it is planned that these meetings will be held in the residence in the near future. The psychologist attends the residence once a week and the occupational therapist is due to give sessional input to the unit. There is no input from the social worker.

INVOLVEMENT IN REHABILITATION PROGRAMMES

Currently residents attend the day centre or a workshop. The residents remain in the residence on Wednesdays to attend to their own individual activities and leisure pursuits. There are active plans to start individual rehabilitation programmes for residents incorporating cookery, shopping, personal hygiene and other activities rather than attendance at the day centre. There are currently three residents on self-medication programmes.

UNIT MANAGEMENT

There are short-term transfers due to bed shortages elsewhere in the service. Meals are cooked in the residence every day and residents get their own breakfasts. The menu is planned with the residents on a weekly basis and at weekends the residents may choose to eat out or get a take-away. Residents do their own laundry. There is one household staff on duty.

HOUSE RULES

There are few house rules except those regarding smoking, consumption of alcohol and aggressive behaviour. The kitchen is out of bounds for a few hours in the morning for cleaning, otherwise there is free access. There are no set bedtimes. Residents collect their own allowances and have their own bank accounts. Some are on budgeting programmes. They can access local transport and the local facilities. Residents do not have their own keys.

SERVICE USER INVOLVEMENT

There is an excellent comprehensive information leaflet for residents and carers. There are community meetings every week between staff and residents.

RECORDS

The clinical files are not kept in the residence. As stated, patients' clinical files are retained in the hospital and do not follow the resident. The quality of some of the transfer and discharge letters was extremely poor and did not allow adequate transfer of information from one care setting to another. There is a separate file for outpatient clinical notes. The nursing notes were satisfactory and the FACE assessment was available. The medication sheets were in good condition. There is a plan to have integrated notes.

ENVIRONMENT

The house is large and comfortable and is due to be repainted. The kitchen was homely and residents had access to it for a few hours each day. There was a sitting room, dining room and also a conservatory with access to a garden that has a gazebo. There was one triple bedroom downstairs. Upstairs there were double rooms. The bathrooms, showers and toilets were satisfactory. Some of the furniture was old and institutional in appearance and needed to be replaced.

MAYSYL LODGE RESIDENCE, FINGLAS

Date of inspection: *16th November*

Number of beds: *13 integrated*

DESCRIPTION

Maysyl Lodge is a residence with 24-hour nursing staff supervision in a rural setting on the outskirts of Finglas. It opened seven years ago and is owned by the HSE. The age range of residents is from 50 to 70 years. The main emphasis of the residence is on continuing care.

REFERRAL AND PROCESS OF ADMISSION

The population in the residence is quite static. Admissions to the unit only occur when there are vacancies due to death or movement to nursing home. These admissions are from St. Brendan's Hospital. All decisions to admit to the residence are taken at the team meeting.

CARE PLAN

There is an Individual Service Plan for each resident. This is based on the Morningside Rehabilitation scale and the care plan is developed along the following headings: living situation, physical health, psychiatric health, education and vocational training, daily living activities, leisure, finances and community network. These are reviewed on a yearly basis. There is no movement of residents to lower levels of support.

NURSING PROCESS

The nursing process is based on the Orem model of nursing. There is no formal key worker or primary

nurse system. There are 2.5 whole time equivalent nursing staff on duty during the day and one nurse and one care assistant on duty at night. The nursing staff rotate between all the residences although the CNM2 is based in the residence.

REHABILITATION TEAM

It was reported that the components of a rehabilitation team exist, consisting of a consultant psychiatrist, nursing staff, NCHDs, and 0.5 whole time equivalent of a social worker. There is no occupational therapist or psychologist on the team. There is a team meeting every three weeks that incorporates all the residences. Residents are reviewed at the outpatient clinic or at the residence. There is one GP for all the residents.

INVOLVEMENT IN REHABILITATION PROGRAMMES

One resident attends a day centre. The other residents remain in the residence. Some are involved in household chores. There are occasional outings and walks. Games, TV and newspapers are available. All residents are involved in a number of daily chores.

UNIT MANAGEMENT

Patients from St. Brendan's Hospital sometimes sleep in the residence due to bed shortages. There is 1.5 whole time equivalent household staff on duty in the residence. The catchment policies are available. There is no waiting list for the residence.

HOUSE RULES

There are house rules pertaining to smoking. Cigarettes and alcohol are bought for patients once a week locally. Some residents are given a cigarette every hour to prevent the weeks' supply being smoked altogether. Visiting times are open. Residents may leave the residence. Staff prepare the meals. There is little input by the residents in the shopping or cooking meals. There is no free access to the kitchen to make tea or coffee during the day. There are no set bedtimes. Allowances are collected by staff and patients have their own bank accounts. A supply of personal cash is kept in the residence, which patients can access when they wish. Personal clothing is bought by the patients, accompanied by staff. Some residents do their own laundry. Community integration is poor due to the location of the residence, although residents can go to the local shop.

SERVICE USER INVOLVEMENT

There is information for residents about the residence and other healthcare services. There is a complaints procedure. There are no formal meetings between residents and staff regarding the running of the residence. There is no input from the Irish Advocacy Network.

RECORDS

The clinical records were up to date. The nursing care plan showed evidence of reviews. The medication sheets were recently updated.

ENVIRONMENT

The residence was homely and comfortable. There was access to small garden and there were plans to erect a gazebo. There was a smoking room and sitting room. The kitchen and dining room were bright and homely. The bedrooms were double rooms with sinks and TV in some rooms. There was a bathroom with a jacuzzi bath and a quiet area on the landing with chairs and an exercise bicycle. There were plenty of personal possessions around the residence and a sense that this was the residents' home. However the whole residence needs to be repainted.

North Dublin

AVONDALE, SWORDS

Date of inspection: *16th November 2005*

Number of beds: *10*

DESCRIPTION

This is a 10-bed community residence with 24-hour nursing staff supervision. The residence opened in 2002 and is approximately two miles from Swords. On the day of inspection, there were eight residents, six male and two female.

REFERRAL

The source of referral is St. Brendan's Hospital. The referral process is through a telephone call from the hospital. The mechanism for assessment is sharing of information between the ward and residence and if the patient is unknown to the residence, staff will visit the patient to carry out an assessment. It was reported that people are transferred without much notice due to bed crisis.

PROCESS OF ADMISSION

There is an admission policy in existence and all residents are discharged from St. Brendan's Hospital. The only exclusion criteria are a recent history of violence or any physical problems. The main reason for admission is to provide continuing care. It was reported that on admission the patient is orientated to the residence. All mental state examinations would have been carried out in the hospital. Each resident is registered with a GP although there are problems with this at present. It was reported that currently GP practices are not taking on any new patients. A new practice has been approached in the area and it is hoped that the situation will be rectified. It was reported that it is a team decision to transfer a resident to the residence. The staff communicate with the residents as much as possible regarding the admission process and encourage contact with family. The consultant psychiatrist carries out a review monthly, or more often when requested by the nursing staff. There is a key worker system in place.

CARE PLAN

Care plans are nurse led and identify nursing needs. The care plans are implemented by the nursing staff and there are specific goals and objectives identified. Care plans are reviewed on a regular basis. Residents do not sign the care plans. It was reported that the majority of residents have been in the residence for some time and that there are no discharges though some residents have been transferred back to hospital.

NURSING PROCESS

The Orem nursing model is used and is described as appropriate to the needs of the residents. It is implemented by the nursing staff and there are minimal elements of a risk assessment.

REHABILITATION TEAM

There is no access to a clinical psychologist or social worker but access to occupational therapy is by referral. There are no counsellors providing a service to the residence. The consultant psychiatrist reviews when requested by the nursing staff.

INVOLVEMENT IN REHABILITATION PROGRAMMES

There is limited evidence of individual programmes. Residents are not involved in programmes to move to lower levels of support and they do not attend day services off site.

CLINICAL RISK MANAGEMENT

There are no formal risk assessments undertaken. Any serious incidents are recorded on appropriate forms and sent to hospital management.

UNIT MANAGEMENT

There are no temporary transfers from the residence although it was reported that when there were vacant beds they have accepted patients from St.

Brendan's Hospital due to bed pressure. It was reported that two residents have recently been moved to a nursing home against the views of the nursing staff. There is a mix of qualified nurses and student nurses in the residence. During the day there are two staff nurses on duty and at night there is one staff nurse and a male nurse's aide. The residence itself has a regular CNM2 but the staff nurses rotate between residences. There is one part-time cleaner and one cook. The cleaner works Monday to Friday 0900h to 1300h and is not replaced when on leave; there are no cleaning staff at the weekend.

ETHOS

The ethos of the residence is to provide a home and continuing care. There are appropriate policies and procedures in place. Maintenance to the residence is provided by St. Ita's Maintenance Department.

HOUSE RULES

There are rules pertaining to smoking and prevention of violence or abuse to staff. Visiting times are at specific times. It was reported and noted that the front door is always locked to prevent people wandering from the residence. The appropriateness of this was questioned by the staff. All other doors from the residence are open but lead into a fenced garden or courtyard area. Residents are not allowed to leave unsupervised. Meals are prepared on site by the cook and residents are involved in meal planning and shopping. Snacks and drinks are made for the residents in between meals. Residents are not required to go to bed at set times or get up at set times in the morning. Residents do not manage their own finances. There is a new policy regarding financial management and capacity to manage finances. Each resident has a post office account and staff collect money for the residents and allocate a daily allowance. Residents are assisted to buy their own clothes. The residents do not access community services unaided. The residence is fairly isolated in terms of local facilities. There is transport available.

SERVICE USER INVOLVEMENT

There is a unit profile which describes the service. The residents have the right to vote. There is a complaints' procedure and follow-up to complaints is appropriate. There is access to an advocacy service.

RECORDS

The residents' names and ID numbers were not evident on all the pages. Entries had full names and titles of personnel and were signed and dated. There were no progress reports from other health professionals. There were infrequent reviews carried out by a consultant psychiatrist and NCHD. The nursing component of the files contained up-to-date care plans. Medication was provided from a GP and it is sent to the residence in blister packs.

ENVIRONMENT

There is regular ongoing maintenance in place. The hygiene of the premises was good, as was the décor. There was personal storage for the residents and there were new wardrobes which were recently installed. The premises consisted of two single bedrooms and the rest were double rooms. Some were en-suite. There was a lounge and smoking lounge, a kitchen, dining room, utility and activity area.

STAFF TRAINING

It was reported that mandatory training is available for staff.

WEIR HOME RESIDENCE, CORK STREET

Date of inspection: *16th November 2005*

Number of beds: *25 integrated*

DESCRIPTION

This is a 25-bed community residence with 24-hour nursing staff supervision. It is situated in Dublin 8, which is outside the catchment area. The main

source of referral is from St. Brendan's Hospital. The residence has been in operation for over 20 years and on the day of inspection there were 25 residents.

REFERRAL

The source of referral is St. Brendan's Hospital and it is reported by staff that the population within the residence is static and that all residents have been in residence for a long time.

PROCESS OF ADMISSION

There is an admission policy in existence. The only exclusion criterion is whether people are uncooperative and abuse alcohol or drugs. The main reason for admission is to integrate into the community. On admission, residents have a mental state examination and are orientated to the residence by nursing staff. Each resident is registered with a GP who maintains their physical well-being. The consultant psychiatrist makes the decision to admit to the residence. The consultant psychiatrist reviews the residents on a weekly basis. The treatment plans are stored in a single file. There is no key worker system.

CARE PLAN

It was reported that care plans are nurse led. However on reviewing the files there was no evidence of any care plans. There were weekly interventions written about the residents but no specific care plans with goals or objectives. It was reported that very few people move on from this residence.

NURSING PROCESS

There is no nursing model in use and as described earlier there is no formal care planning process. There are no individual risk assessments carried out on any of the residents.

REHABILITATION TEAM

There is no access to clinical psychology or occupational therapy and there is limited input from a social worker. There is one consultant psychiatrist who visits the residence on a weekly basis.

INVOLVEMENT IN REHABILITATION PROGRAMMES

There is a therapy area within the premises and activities are facilitated by the activation nurse; art therapy is provided on a sessional basis. There are no formal programmes for moving people onto a lower level of support. Some residents attend local day centres.

CLINICAL RISK MANAGEMENT

There is no evidence of policies on clinical risk management. Any serious incident is recorded on appropriate forms.

UNIT MANAGEMENT

Residents are not transferred on a temporary basis to other units. The residence is not used for any other purpose although it was reported that on occasions the local residents make use of the premises for facilitating parties. The staff in the residence are all qualified nurses. There are three nurses on duty during the day and two at night. Staff are provided from a central roster. There are two household staff.

ETHOS

The ethos of the residence is to provide a home. There is no formal process of induction for the residents or staff. There are hospital policies in place but nothing specific to the residence.

HOUSE RULES

Residents are asked to be in at a reasonable time at night and to smoke only in appropriate places. Visiting times to the residence are flexible. Residents

do not have a front door key or a bedroom key. They are allowed to leave unsupervised but are not required to check in or out. Breakfast and evening meal is prepared on site but the dinner is sent from Usher's Island. Residents are not involved in menu planning or shopping but they have free access to the kitchen to make drinks or snacks. Residents are not required to go to bed or to get up at set times and all have single rooms. Most of the residents manage their own finances. Some need assistance. There is a policy in place regarding financial management. Residents buy their own clothes in local shops and have access to the utility room. Most of the residents use the services in the community unaided. All facilities are within walking distance and there is also access to public transport.

SERVICE USER INVOLVEMENT

There is some information on treatment therapies. All the residents have the right to vote. There is a formal complaints policy.

RECORDS

The residents' names and ID numbers are not evident on all pages of the files. Entries have full names and titles of personnel and are signed and dated. There are no progress reports from other health professionals and there are no treatment plans. The written interventions from the consultant psychiatrist occur when he is asked to see the residents by the nursing staff. The nursing files do not have the residents' name and ID number on all pages. Medication cards are appropriate.

ENVIRONMENT

This is a very large three-storey building situated in the centre of Dublin. There is regular maintenance in place. All residents have a single room and can personalise it. The residence consisted of 23 single rooms and one double room. There is a therapy room, dining room, kitchen and pantry, toilets, bathrooms on each floor and a lounge are on the ground floor.

STAFF TRAINING

It is reported that staff are encouraged to attend for mandatory training.

ST. JOSEPH'S INTELLECTUAL DISABILITY SERVICE

DUNHAVEN UNIT

Date of inspection: *21st November 2005*

Number of beds: *16 integrated, 8 male, 6 female*

DESCRIPTION

Dunhaven is a locked unit in St. Joseph's Intellectual Disability Service. It serves as an admission unit as well as a unit for residents with challenging behaviour and also occasionally provides respite care. The age range is from 20 to 49 years. On the day of inspection, all residents were of Voluntary status.

REFERRAL

Residents are referred from community residences within the service and from the voluntary services. Currently there are five residents in the unit from outside the service area. If beds are available there are occasional respite admissions.

PROCESS OF ADMISSION

All referrals to the service are assessed by the consultant psychiatrist and information is passed to the unit staff prior to admission. As the unit is gender integrated, residents with a history of severe challenging behaviour or sexualised behaviour are not admitted to this unit. No children are admitted to the unit. Residents have an initial mental health assessment and physical examination following admission. All new admissions are seen by the consultant psychiatrist within 48 hours of admission. There is an admission policy and residents are not nursed in their night clothes on admission.

North Dublin

CARE PLAN

The nursing care plan is based on Maslow's assessment of needs. The care plan is reviewed every one to two months for new residents and every six months for long-stay residents. Each resident has a behavioural assessment based on adaptive behavioural scales and this also contains a clinical risk assessment. A number of residents have been assessed by the behavioural therapists and are on behavioural programmes, and both residents and families are involved in these programmes where possible. Residents attending the education centre have regular formal assessments of their progress and these are filed in the clinical files.

NURSING PROCESS

There are seven nursing staff on duty during the day and three nursing staff on duty during the night. There is a primary nurse/associate nurse system in operation. The unit is mostly self-staffing and there is good continuity of staff. There are two levels of observation: general observation and special nursing.

ACCESS TO THERAPY

There is no psychologist, social worker or occupational therapist in the service. There are two behavioural therapists who see residents on request. There are no regular team meetings with the consultant psychiatrist on the unit. However, consultant psychiatrists attend the unit at least once a week. The NCHD attends the unit daily. Physical needs of residents are dealt with by a visiting GP. The NCHDs reported that this can be variable at times, and there have been no routine physical examinations for over 18 months.

ACCESS TO THERAPEUTIC PROGRAMMES

There are a number of activities available for residents off the unit. Each resident is referred to the day services for particular programmes such as Montessori education, gym, multi-sensory therapy and art therapy. Other activities such as outings, walks, swimming and horse riding are also available.

SECLUSION

Seclusion is carried out on the unit. The seclusion register was signed by the NCHD and up to date. Seclusion was, on average, carried out for between one and two hours and the time is documented in the register. Staff stated that they attempt to provide post-seclusion feedback to the resident. Some residents are locked in their rooms at night but this is not documented as it is not deemed seclusion under the Mental Treatment Act 1945. An audit of seclusion has been carried out over the previous two years and was available. The seclusion room was completely padded and the padding was clean. There was ventilation but the room was extremely stuffy. There is CCTV in the seclusion room.

CLINICAL RISK MANAGEMENT

There is a location alarm system. The hospital policies were available on the unit. There were specific risk policies for this unit. There is no policy on restraint. One resident is sometimes in an all-in-one suit which is zipped at the back but allows full movement of arms and legs, the aim being to prevent the resident from taking off his clothes. This is part of his behavioural programme and is documented in his clinical notes. There are no other forms of mechanical restraint currently being used on the unit. Staff are trained in crisis intervention. There is a new computerised system of reporting serious incidents in operation. It is hoped that there will be feedback of audits of serious incidents to the staff in the units.

UNIT MANAGEMENT

There are six-monthly meetings in the unit which concentrate on the use of restraint and seclusion as well as other management issues in the unit. There are also regular unit meetings with nursing staff, to discuss residents' progress and management issues. Minutes are taken at both these meetings. CCTV is only used in the seclusion room. There are two household staff on duty. All residents had personalised clothing which had name tags. Personal laundry is done on the unit.

North Dublin

SERVICE USER INVOLVEMENT

Due to their profound and severe intellectual disability most of the residents are unable to access written information about the service. There is a friends and parents support group that meets regularly with the service management.

RECORDS

The clinical files showed evidence of regular psychiatric review. However there were no physical examinations for at least 18 months. Medicine sheets were legible, signed and dated, and discontinuation of medication was also signed and dated. The care plans were up to date and behavioural programmes were in place for some residents.

ENVIRONMENT

Dunhaven was located within the hospital on the first floor. This meant that there was no access to an outside space. The condition of the unit was not good. There was a large day room with a TV and DVD player. There was a second day room, which provided space if residents were agitated. Ball games are sometimes played in this room. The dining room was too small and meal times are staggered. The kitchen was in poor condition with seals leaking around the sink, the window frames were not suitable in a kitchen area and the room required replastering and repainting. There were a number of residents on the unit who were not involved in any activities or stimulation. There was a toilet and bathroom off the day room that needed to be repainted, tiled and resealed. There was a male dormitory that had little privacy – it had some partitioning but no curtains around the beds. The wardrobes needed replacing. There were two single rooms adjoining the dormitory that needed repainting. There was a female resident in one of these single rooms who was locked into her room at night. The female dormitory was very run down and also needed repainting and replastering, along with some new wardrobes. There were two cubicles divided by partitions. A male resident slept in one of these cubicles. There was a Parker bath in the female dormitory.

DÚN NA RÍ (UNIT 11)

Date of inspection: *21st November 2005*

Number of beds: *19 male*

DESCRIPTION

Dún na Rí is a stand-alone locked building in the grounds of the hospital. The unit caters for male patients with severe challenging behaviour with intellectual disability. The age range of patients is from 21 to 55 years. On the day of inspection, there were no patients detained under the Mental Health Act 1945 in the unit.

REFERRAL

Most patients are referred from community residences within the service, from the voluntary services and from the generic intellectual disability services. There have been five admissions since January 2005. All referrals to the service are assessed by the consultant psychiatrist, who meets with the unit staff prior to the patient's admission to discuss treatment plans.

PROCESS OF ADMISSION

There is an admission policy. No children are admitted to the unit. Most admissions are planned but there are occasional urgent admissions. Patients have an initial mental health assessment and physical examination following admission. All new admissions are seen by the consultant psychiatrist within 48 hours of admission. Patients are not nursed in their night clothes on admission.

CARE PLAN

There is a nursing care plan, based on Maslow's assessment of needs. The care plans are reviewed between two and six months and there is a re-assessment every year. Each patient has a behavioural assessment based on adaptive behavioural scales, which also contains a clinical risk assessment. A number of patients have been assessed by the behavioural therapists and are on behavioural

programmes and both patents and families are involved in these programmes where possible.

NURSING PROCESS

There are six nursing staff on duty during the day and two nursing staff and one care assistant on duty during the night. There is a primary nurse/associate nurse system in operation. The unit is mostly self-staffing and there is good continuity of staff. There are two levels of observation: general observation and special nursing.

ACCESS TO THERAPY

There is no psychologist, social worker or occupational therapist in the service. There are two behavioural therapists who see patients on request and have developed behavioural programmes with a number of patients. There are no regular weekly team meetings with the consultant psychiatrist on the unit. However, consultant psychiatrists attend the unit at least once a week and meet with staff once a month. About once a month the staff have a meeting with the consultant psychiatrist. The NCHD attends the unit daily. Physical needs of patients are dealt with by a visiting GP. Apparently there have been some difficulties in the regularity of this service and there have been no routine physical examinations of patients for over 18 months. Access to general outpatients in Beaumount Hospital can be problematic due to long waiting times.

ACCESS TO THERAPEUTIC PROGRAMMES

There are a number of activities available for patents off the unit. Patients can be referred to the day services for particular programmes such as Montessori education, the educational centre, signage classes, gym, multi-sensory therapy and art therapy. Other activities such as outings, walks, bowling, swimming and horse riding are also available. There is some limited access to speech therapy.

SECLUSION

There is seclusion carried out on the unit. The seclusion register is up to date and is signed by the NCHD. The seclusion register shows relatively short seclusion periods of, on average, one to two hours' duration. Documented 15-minute checks are carried out. Seclusion episodes have dropped significantly in the case of one patient over a two-year period, during which time a behavioural programme was initiated. Seclusion and restraint are currently being audited with a view to a new policy on seclusion and restraint.

The seclusion room is padded with outside control of light. It had ventilation and had CCTV. The padding was smeared with blood due to the fact that a patient recently in seclusion had a superficial head laceration. Request by staff for urgent cleaning had been made but they were unsure when the cleaning would take place. Staff were advised by the Inspectorate that the seclusion room must not be used until the padding had been cleaned.

CLINICAL RISK MANAGEMENT

Mechanical restraint is used on this unit in the form of a straitjacket in the case of one patient. This is recorded in the register and signed by the medical staff. The duration of use of this restraint is recorded as lasting from 30 to 40 minutes once or twice a day and is used to prevent serious self-injury. Due to the introduction of a behavioural programme, the frequency of use of this restraint has been reduced. However, it is unacceptable that this form of restraint continues to be used in a modern mental health and intellectual disability service. The Inspectorate was informed that efforts are being made to provide alternatives, which including psychological treatments, extra staffing and staff training.

Policies were available on the unit. There was no policy on rapid tranquillisation available. Staff are able to avail of a wide range of training opportunities provided by the school of nursing. All staff are trained in crisis prevention intervention. Serious incident reporting was recently changed to a computerised system and it is hoped that staff on the unit will receive formal feedback from audits of serious incidents. Policies and procedures in risk management are being introduced.

North Dublin

UNIT MANAGEMENT

There are no short-term transfers to this unit to relieve bed shortages elsewhere. CCTV is used in the seclusion room. Bedtimes are flexible. Ongoing maintenance of the unit is difficult to obtain. There is no waiting list for the unit.

SERVICE USER INVOLVEMENT

Due to their profound and severe intellectual disability the patients are unable to access written information about the service. There is a friends and parents support group that meets regularly with the service management.

RECORDS

The clinical files showed evidence of regular psychiatric review. No physical examinations of patients had been carried out for at least 18 months, which is unacceptable. Medication sheets were legible, signed and dated, and discontinuation of medication was signed and dated. Some medicine sheets appeared to be overcrowded with entries. The care plans were up to date and there was evidence of behavioural therapy plans in some care plans.

ENVIRONMENT

The unit is a single-storey stand-alone unit comprising of two wings: East wing and West wing. There was an enclosed area outside that had been developed through fund-raising. The unit was also functionally divided, with 12 patients in the West wing and seven patients in the East wing. Both wings were allocated dedicated staff. The corridor was divided by a number of half-doors which could be locked while still allowing observation. The unit was very bare, with special unbreakable chairs. There were three institutional-type bare day rooms in total, with TVs. Some areas had pictures on the wall. The windows were made of plastic glass. There were a number of single rooms and patients were locked into the rooms at night. Apart from one personalised room, the rooms were completely bare except for beds. There was a three-bed dormitory, and two four-bed dormitories which had wardrobes but had no curtains. They were bare of any décorative features. The toilets had recently been painted and were clean. There were seating areas in the hallways. The dining room was bright and divided down the middle by the kitchen. There were two nurses' offices, a visitors room and a clinic room.

Nineteen patients is an excessive number in a unit specialising in challenging behaviour and the unit itself was unsuitable for these patients.

LA VISTA

Date of inspection: *21st November 2005*

Number of beds: *20 male*

DESCRIPTION

This is a 20-bed open unit for men with a severe intellectual disability. On the day of inspection, there were 15 patients. There were no patients detained.

REFERRAL

There are no new referrals to this unit. The population is described as static and the needs of the patients are long term. The physical needs are maintained by a visiting GP or a NCHD out of hours. The staff on the unit try to involve family members wherever possible. The only observation level is special observation, where the patient is within arm's length or close proximity.

CARE PLAN

Care plans are purely nurse led. Goals and objectives are needs identified, following a comprehensive assessment. A key worker and a co-key worker are identified, and they are responsible for implementing the care plan.

NURSING PROCESS

The nursing model used is the human needs model, which is described as appropriate to the needs of the patients. It is implemented by the key worker. There is no formal risk assessment undertaken.

North Dublin

ACCESS TO THERAPY

There is no psychology input. Activities are provided by nursing and care staff from various centres within the hospital. There is no social worker input nor are any services provided by specific counsellors. There is one consultant psychiatrist who has responsibility for patients within the unit and there is a six-monthly review undertaken. It was identified that there is need for physiotherapy input onto the unit.

ACCESS TO THERAPEUTIC PROGRAMMES

Some of the patients go to the retirement centre in the main hospital complex or participate in activities on the unit. The rest of the patients are taken on trips out and for walks.

SECLUSION

There are no seclusion facilities.

CLINICAL RISK MANAGEMENT

There is a policy committee within the hospital whose responsibility it is to oversee the implementation and review of policies. It was reported that they are developing a policy with regard to mechanical and physical restraint. There is an alarm system in operation which is tested weekly. There are policies on patients absconding, the management of violent episodes, rapid tranquillisation and giving medication without consent. The staff reported they receive training in control and restraint techniques which includes de-escalation and breakaway techniques. Staff also receive cardio-pulmonary resuscitation training, manual handling and have access to longer courses which are fully supported by hospital management. There is clinical risk assessment in each of the patient's charts on the use of cot sides, restraining belts and body suits. Serious incidents are recorded on appropriate forms and sent to administration.

UNIT MANAGEMENT

There are no temporary transfers to other units within the hospital on a long-term basis. The patients are allowed off the unit accompanied by staff. The doors of the unit are open. There are four staff nurses and four care staff on duty during the day and at night there are two staff nurses and one care staff. There is core staffing for the unit but if any extra staff are needed they are taken from a central roster. There is a process of induction for staff. The dress code is uniform but the attire worn by the staff appears casual. Maintenance to the unit is provided by the on-site maintenance department and this is described as satisfactory. Visiting times are open. The meals are at set times and snacks and drinks are provided during the day.

SERVICE USER INVOLVEMENT

There is some information on treatment and therapies available. There is a complaints procedure. Complaints are investigated at unit level and if necessary referred on to management.

RECORDS

Patients' names and ID numbers were evident on all pages of the files. The files were legible and tidy and had appropriate entries. They were signed and dated. There were no progress reports from allied health professionals. There was a nursing and medical treatment plan. The recording of reviews was undertaken by the consultant psychiatrist but there was no evidence in the notes. It was evident that the NCHD recorded interventions when asked to see the residents or on a six-monthly basis. The nursing files were legible and tidy and contained comprehensive assessments and care plans that were relevant and up to date. Medication cards were signed, dated, legible, used generic names and discontinuation of medication was signed and dated.

ENVIRONMENT

This was a 20-bed unit on the ground floor situated within St. Joseph's Hospital. There was a regular maintenance programme and disabled access. The

lighting and ventilation were good and there was a reasonable standard of décor. There was no designated visitors' area but there was access to a garden. The bedroom area was a large dormitory. There was one patient who is locked in a single room at night and the staff regard this as seclusion and it is recorded appropriately. There is wardrobe space for each patient and they all have their own clothes. There is an adequate number of toilets and bathrooms and the majority of the patients require assistance with using the toilet. The dining area has space for all patients at one sitting, it is shared with the unit next door and a number of the patients require feeding. The lounge areas contained appropriate seating although some patients were in chairs which restricted their movement. There was a TV, video and radio. The nurses' station was central to the day area. It was of adequate size, there was space for report writing and it was accessible. There was a telephone system but no IT. The clinical room had appropriate medical equipment, cardio-pulmonary resuscitation equipment and drug storage. There was adequate storage for patients' possessions, money, files and records, medication, catering and linen.

RUSHBROOK UNIT

Date of inspection: *22nd November 2005*

Number of beds: *15 male*

DESCRIPTION

Rushbrook Unit is a locked two-storey unit in the grounds of St. Ita's Hospital. It was previously three houses which are now joined together. There are no patients in the unit detained under the Mental Treatment Act 1945 and there is one Ward of Court. The age range of patients is from 30 to 80 years and the main emphasis is on continuing care. It was planned that this unit was to close but that plan has now been suspended.

REFERRAL / PROCESS OF ADMISSION

Most of the patients in this unit are long-stay patients and there have been no admissions for a number of years. There may very occasionally be short-term respite admissions. All respite admissions are referred by the consultant psychiatrist.

CARE PLAN

The Logan Roper Tierney nursing model is used on this unit. It is felt by staff to be appropriate to this patient group. Care plans are reviewed every few months and there is an annual reassessment of each patient.

NURSING PROCESS

There are three nursing staff on duty during the day and one nurse and a care assistant on duty at night. There is a primary nurse system in operation and good continuity of staff.

ACCESS TO THERAPY

No psychologist, social worker or occupational therapist is involved in the service. There are two behavioural therapists who see patients on request. There are no regular team meetings with the consultant psychiatrist on the unit. However, consultant psychiatrists attend the unit at least once a week and the NCHD attends the unit every two or three days. Physical needs of patients are dealt with by a visiting GP. There have been no routine physical examinations for over 18 months.

ACCESS TO THERAPEUTIC PROGRAMMES

Eleven patients attend the day services where there are a number of activities available for patients off the unit. Each patient is referred for particular programmes, such as Montessori education, gym, multi-sensory therapy and art therapy. Other activities such as outings, walks, swimming and horse riding are also available. Four patients are retired and usually spend their time in the unit.

SECLUSION

There is no seclusion used on this unit

North Dublin

CLINICAL RISK MANAGEMENT

Staff carried personal alarms. The service policies were available on the unit. Staff have access to training in crisis prevention and other courses run by the school of nursing. No restraint was used on the unit.

UNIT MANAGEMENT

There is a monthly management team meeting with nursing staff which is held on the unit. Bedtimes are flexible. There are no short-term transfers due to bed shortages in other parts of the service. There are two household staff and some patients have small chores. There is access to a minibus every 10 days for shopping trips and other outings.

RECORDS

The clinical files showed evidence of regular psychiatric review. However there had been no physical examinations for at least 18 months. Medication sheets were legible, signed and dated. Discontinuation of medications was signed and dated. The care plans were up to date.

ENVIRONMENT

The unit was quite dark and gloomy, with narrow corridors and stairs, and was in need of redecorating. There was an extension at the back which connecting the three original houses. The bedrooms varied between single, double, triple and four-bed rooms. There were few personal possessions and the rooms were very neat. All patients had their own clothes and wardrobes and some wardrobes could be locked. There was a disabled shower. There was a smoking room and two sitting rooms with radio and TV and rather institutional furniture. The kitchen was very clean and nicely décorated. There was a large nurses' office.

ST. FIACHRA'S UNIT

Date of inspection: *21st November 2005*

Number of beds: *15 beds, 7 male, 8 female*

DESCRIPTION

This is a locked 15-bed unit for people with severe intellectual disability who exhibit challenging behaviour. On the day of inspection, there was one person who was a Ward of Court.

REFERRAL

The source of referral to the unit is the day services in the community and also certain services out of area. Referrals are through a consultant psychiatrist usually in response to a crisis.

PROCESS OF ADMISSION

On admission, the registrar carries out an admission assessment and the nursing staff undertake a nursing assessment. There is a physical examination undertaken and the GP follows this up. A collateral history is obtained and the person making the decision to admit is the consultant psychiatrist. Communication with the patients is difficult due to the severe nature of their learning disability. Contact with family is encouraged. The consultant psychiatrist reviews all new admission within 24 hours. Patients are not nursed in night clothes during the day. It was reported that one patient is in an all-in-one suit and has to have restraining clothes on during the day. There are two levels of observation – special observation, where a nurse remains in close proximity, and close observation, in line of sight. There is a key worker system and the nursing staff are allocated to a group of patients.

CARE PLAN

Care plans are nurse led. Following a comprehensive assessment, needs are identified and goals and objectives are established. Care plans are reviewed as needed and involve appropriate people in meeting the needs wherever possible. At time of discharge there is a gradual discharge plan put in place.

North Dublin

NURSING PROCESS

The unit uses the Maslow Hierarchy of Human Needs model, adapted slightly. There is a key worker who implements the care plan. It was reported that the service is in the process of developing a risk assessment tool.

ACCESS TO THERAPY

There is no access to a psychologist or social worker. In the past there was an occupational therapist who carried out a chair and bed assessment but there is no longer regular access to an occupational therapist, though there is access to a behavioural therapist, who appears to have made a significant difference to the patient group on this unit. There is one consultant psychiatrist who has responsibility for the patients on the unit and who carries out a weekly review. The NCHD calls daily.

ACCESS TO THERAPEUTIC PROGRAMMES

The programmes are all individual. There is an excellent sensory room on the unit, to which all patients have access. Two of the patients attend day services and one attends industrial therapy. There is also access to Montessori school and a number of the patients go out for walks.

SECLUSION

There is no dedicated seclusion room, although one of the patients is locked in at night and this is defined as seclusion on this unit. The appropriate register is maintained.

CLINICAL RISK MANAGEMENT

The unit has recently had a very comprehensive risk assessment carried out and a draft report was available for inspection. The unit is in the process of developing an individualised risk assessment, looking at the issues regarding seclusion at night, restraining gloves, posy restraints and cot sides. There is an alarm system in operation. There are various policies in place. The staff reported they had received training in control and restraint techniques, including de-escalation and breakaway techniques. There has been some training for cardio-pulmonary resuscitation but it was reported that the staff need an update. There was also other mandatory training and also training in the Mental Health Act, 2001. There is support for staff to attend long courses. There is a reporting mechanism for serious clinical incidents.

UNIT MANAGEMENT

There are no temporary transfers to other units within the hospital, or long-term transfers elsewhere. One of the patients can leave the unit unaccompanied, the rest are accompanied by staff. The door is always locked. There are four staff nurses and three care assistants on duty during the day. There is one CNM on the unit. At night there are two staff nurses and one care assistant. The unit is self-staffing. There is a process of induction for staff. It was reported that two of the current patients are awaiting appropriate placement elsewhere. Maintenance is provided by the on-site maintenance team and it was described as a poor response at present due to the increasing workload. Visiting times are open. Meal times are at set intervals and there is availability of snacks and drinks between meals.

SERVICE USER INVOLVEMENT

There is some information available about the unit and treatments. There is a complaints procedure. It was reported that six of the current patient group used to be restrained at meal times but following interventions of the behavioural therapist and the nursing staff this is no longer the case and these people sit at the table and have their meal.

RECORDS

The patients' names and ID numbers were evident on the pages of the notes. The files were legible and tidy and had regular updates from the medical staff. There was a treatment plan and progress reports. Nursing care plans were detailed, relevant and up to date and were regularly reviewed. Medication card indexes were all signed, dated and legible, and used generic names. Discontinuation of medication was signed and dated.

ENVIRONMENT

This was a large unit all on the ground floor. It is an isolated unit in the grounds of St. Joseph's Hospital. There is disabled access. There was access to a garden area which was fenced. There was a mixture of bedroom facilities. Some of the rooms had been adapted to meet the requirements of the patients' challenging behaviour. The main dormitory was of a good standard. Everyone had an individual wardrobe space. There were an adequate number of toilets and bathrooms. The dining area had space for all patients at one sitting, was integrated and appropriate for the needs of the patients. There was a sensory room, which was an excellent facility. On the day of inspection, all of the patients were using this facility and it was closely supervised by the staff. The unit was spacious although this can cause problems for staff supervising the patients. The nursing station was central to the unit. The clinical room contained all the appropriate medical and cardio-pulmonary resuscitation equipment.

TARA UNIT

Date of inspection: *21st November 2005*

Number of beds: *13 male beds*

DESCRIPTION

Tara unit is located in St. Ita's Hospital. It caters for patients with profound intellectual disability and who also require full nursing care. Most patients are incontinent, also have physical disabilities and patients may be on PEG (tube) feeding. The majority of patients need to be assisted with feeding. All have severe communication difficulties. It is a locked unit and there are no detained patients or Wards of Court.

REFERRAL / PROCESS OF ADMISSION

There are no admissions to this unit. Discharges are only to nursing home care. Vacancies are not filled and it is expected that this unit will eventually close although there are no clear plans regarding this.

CARE PLAN

The care plan is based on the Maslow Hierarchy of Human Needs. These are reviewed every three months. Most of the care plans are mainly concerned with physical needs.

NURSING PROCESS

There are five nursing staff on duty and two care assistants on duty during the day. There is one nurse and one care assistant on duty at night. There is a primary nurse system in operation which is aided by good continuity of staff. Most of the nursing staff time is spent providing physical care such as feeding and changing.

ACCESS TO THERAPY

There are no psychologists, social workers or occupational therapists in the service. The consultant psychiatrist visits the unit every two weeks and when required. The NCHD visits daily. It was noted that there are some difficulties in obtaining reviews by GPs.

ACCESS TO THERAPEUTIC PROGRAMMES

Two patients attend the retirement centre which has activities for older patients such as reminiscence therapy, exercise, knitting, jigsaws, relaxation and socialisation. Two other patients attend the multi-sensory therapy. Others, if they are able, go on outings or watch TV.

SECLUSION

There was no seclusion carried out in this unit.

CLINICAL RISK MANAGEMENT

The service policies were available on the unit. All policies are currently being reviewed. One patient is in an all-in-one suit at night and this is written in the clinical file. One patient requires a table across his

chair to prevent him falling. There is ongoing training for nursing staff. The reporting of serious incidents is through a new reporting system.

UNIT MANAGEMENT

There are unit meetings every month at which minutes are taken. There is one member of household staff on duty during the day. Meals are provided from the central kitchen.

RECORDS

The clinical files showed evidence of regular psychiatric review. No physical examinations of patients had been carried out for at least 18 months, which is unacceptable. Medicine sheets were legible signed and dated, and discontinuation of medication was signed and dated.

ENVIRONMENT

Entrance to the unit is through the dining room, which has a small kitchen to the side. Most of the unit required repainting. The day room was large and efforts had been made to make it as bright and comfortable as possible. There was a TV area with two reclining chairs and a sofa. The toilets were in poor condition. There was a large dormitory with 20 beds; all had curtains around them and each had individual wardrobes. A number of the beds were not being used. There was one single room which was bare except for a bed. The night office had various items stored in it and had no desk, only a sofa. While the unit is on the ground floor and there is access to the grounds of the hospital, there is no enclosed safe garden area which prevents a number of patients accessing fresh air.

ASHLEA UNIT

Date of inspection: *22nd November 2005*

Number of beds: *16 male*

DESCRIPTION

Ashlea is a 20-bed ground floor unit located at the rear of St. Joseph's Hospital. It is a long-stay residential unit currently catering for 16 residents ranging in age from 42 to 82 years of age. The majority of residents are of high dependency and this unit was initiated as an extended nursing care unit. At least half of the residents do not have full mobility. Residents generally have a learning disability in the mild to severe range but those with mild learning disability have both physical and behavioural problems.

REFERRAL / PROCESS OF ADMISSION

As this is not an acute unit there are no admissions to the service. The one documented admission during the last year was effectively a re-admission after a failed placement. Patients here have been in the service for many years

CARE PLAN

There is no multidisciplinary care planning. There is no occupational therapist, social worker or psychologist available to the unit.

NURSING PROCESS

The nursing care plan in use is based on the human needs model of nursing. The key worker organises the care plan and it is reviewed at least every six months. An individual personal plan is then developed. The assessment includes five categories, as set out in the human needs model. Staff find it very appropriate to needs and have developed a sophisticated evaluation system. There is a staff meeting every six weeks on the unit to cover issues such as leave and induction, and to check that all care plans are being reviewed. There is a key worker system in operation. Two key workers are assigned to

each resident and the primary key worker does each assessment and the care planning.

There is a policy regarding general observation. Care staff wear uniforms. The nursing staff have a dress code involving a uniform for the female staff and a code for the males.

ACCESS TO THERAPY

There is no access to a clinical psychologist, occupational therapist or social worker. The consultant psychiatrist attends the unit when asked. The NCHD attends daily. One GP provides services to St. Joseph's Hospital and he visits the hospital every day. He attends the unit on request. The psychiatric NCHD performs the six-monthly physical examination. The GP attends to a patient with an indwelling catheter whereas nursing staff catheterise another patient on a regular basis.

Medical and surgical consultation is available from Beaumont Hospital. There is an X-ray service on site. Staff are satisfied with access to laboratory and X-ray results. Due to the shortage of nursing staff throughout the service a lot of overtime is worked. A barber and chiropodist also attend the unit.

ACCESS TO THERAPEUTIC PROGRAMMES

There are no groups conducted on the unit due to the level of dependency and disability of the patients. A lot of individual work is conducted around issues of mobility. There is a massage chair and a jacuzzi feature in the bath. Specialised equipment has been brought in to facilitate transporting and sitting arrangements for the residents. Part of the unit has had improvements made and is called "the solarium". Patients are brought up there for some quiet time and for the use of the massage chair. Eight of the residents attend training areas outside the unit, ranging from arts and crafts to the retirement centre. Those confined to the unit engage in unit activation programmes. A multi-sensory room is available in the courtyard. The Montessori service consists of two teachers. All residents attend the Montessori service on an infrequent basis. This is found to be most useful. Staff organise outings for residents particularly during the summer months to a holiday home in Wexford. They also arrange trips to the shops and local amenities. A few residents go on passes on a regular basis.

ECT AND SECLUSION

Not applicable.

CLINICAL RISK MANAGEMENT

There are good practice guidelines on risk assessment available. There was a policy on observation with levels specified. The safety statement regarding hygiene and cleaning were also available. There is an alarm system in operation on the unit. There is no policy on alcohol and illegal drugs. There is a policy on patients absconding and the management of violent episodes. There is no policy on rapid tranquillisation or on searching patients' belongings.

There is no mechanical restraint in use. However cot sides are used for safety reasons. The use is documented in files by the NCHD and is also documented in the care plan and there is a seclusion and restraint register. There is no physical restraint policy nor is physical restraint used. There is a policy on mechanical restraint although mechanical restraint is not used on this unit either. All nursing staff in this unit have trained in control and restraint according to the nursing members interviewed. There is no training in de-escalation or breakaway techniques. There are regular refresher courses available on cardio-pulmonary resuscitation and lifting. There are regular fire drills and fire prevention lectures and lectures regarding hygiene. Clinical risk assessment is being introduced with a view to individual risk assessment documentation in the patients' charts. Serious incidents are reported on a standardised incident report. Reports are sent to the hospital administrator, the health and safety officer and a copy is kept on the unit. There is a new incident report in use for the last eight months for the entire HSE Northern Area which covers "near misses" as well as actual incidents. Counsellors are available from Health and Safety for debriefing after serious incidents if required.

North Dublin

UNIT MANAGEMENT

There are no temporary transfers to other units. A number of residents have been transferred to nursing homes specifically set up for patients with learning disability. These moves have occurred as a result of discussions by the rehabilitation committee.

This is an open unit and residents have free access. The door is only locked at night time. There is no CCTV on the unit. There are three nursing staff on by day and a CNM1. There is one staff nurse on at night. Nursing staff are rostered to the unit. The care assistant staff are centrally rostered and there are between two and four care assistants on day duty and one care staff member on at night. There is an induction checklist for new staff and students. A recent education initiative, the FETAC Health Care Support Programme, that give certified training has been introduced. There is no unit clerk and nursing staff generally take bloods when required. There is no waiting list on the unit. At the time of inspection none of the patients was deemed ready for discharge to a lower level of support. Maintenance was reported as not satisfactory. The unit needs to be redécorated. Because of the ongoing doubts about the future of St. Joseph's Hospital, little ongoing capital development has occurred. Visiting times are flexible and meal times are at 0900h, 1200h and 1630h, with snacks at 1030h, 1430h, 1830h and 2030h.

SERVICE USER INVOLVEMENT

Most families are described as being very involved. They are not formally involved in care planning but they are often asked to continue the programmes that have been set out in the Individual Patient Plans (IPPs), particularly while the patient is out on pass. There is a hospital policy regarding complaints and the follow-up of complaints. The resettlement committee seeks opinions from families and carers regarding resettlement. There are no unit staff on the resettlement committee and there are no unit community meetings with the patients. There is no formal access to advocacy although there is access to the parents' council. The parents' council is not represented on the resettlement committee either. Two patients were seen briefly and they appeared well cared for. They were very physically dependent.

RECORDS

Medical files were of a variable standard and were not always legible. There was a sleeve at the back for correspondence. A medical signature bank was unavailable. Entries had the full name but not the title of the personnel making the entry. They did not contain progress reports from allied health professionals. There was a treatment plan in the nursing care plan. It contained dated and signed progress reports. There was little evidence of any consultant review and the NCHDs reviewed depending on medical need. There seemed to be little NCHD input into psychiatric evaluation. Nursing files were satisfactory although the patient name and ID number was not on all the pages. They were legible and tidy and they entered the full name. All the entries were dated and signed and there was a signature bank available. The medication, prescription and administration records were satisfactory. Discontinuations of medication were signed but not always dated.

ENVIRONMENT

This is a spacious ground floor unit that needs upgrading. There is disabled access. Ventilation was satisfactory. There were posters on the walls regarding the philosophy of the unit. There was no clerical support. There was a computer and printer available on the unit. There was no visitors' area although there were seats at the end of the unit outside the single rooms. There was access outside to a park area with benches but no garden set aside. Access outside had been sought to enable a smoking area to be developed there but a preservation order prevented this. There was no reception area. There were four single bedrooms and the remaining 16 beds were in the dormitory. Four of these at the time of inspection were unoccupied. There was wardrobe space. The décor was generally run down.

With regard to the toilet and bathrooms, the majority of patients required assistance and proper staff washing and toilet facilities were required. There was a Parker bath and a disabled or sit-down shower. There was a hoist. There were no en-suite facilities. The majority of residents had two baths per week. There were no overriding locks on the bathrooms. Very few of the residents are able to go to the bathroom unassisted.

There was a smell from the kitchen area due to impaired drainage or sewage which was quite detectable at the end of the unit, from outside the single rooms and the solarium area. The dining area was part of the day room/sitting room. Many of the residents were fed in their bed or chair. Five were spoon fed at the table and eight were on liquidised diets. The sitting-cum-dining room had TV. There was no exercise or activity area on the unit. Residents who are able attend the multi-sensory room or the retirement centre in the courtyard or go for walks. None of the patients go to the gym. There was a day room, one dormitory, an office, a clinical room, a sluice room and five single bedrooms. There is one toilet area off the general sitting room and one bathroom. A nurse station is situated off the dormitory. Newspapers are delivered each day along with magazines. An area at the back has been converted and carpeted and was described as "the solarium". The windows here were opaque. It had a TV and some comfortable seating.

The nurses' station was used as the interview room. It was central but not particularly confidential. There was adequate space for report writing and there was a computer available. The clinical room contained an emergency trolley. Cardio-pulmonary resuscitation equipment was available in Unit 12 just outside, across from the unit. There was no clinical examination couch, examinations being performed at the bedside. Staff had a room for sitting and study and a toilet. There was no light in the staff toilet although there was some glass on top allowing light in from the outside area. Files and records are kept in the nursing office. Medication is kept in the clinical room. Catering was conducted off site. There is no seclusion.

CARRIGLEA

Date of inspection: *21st November 2005*

Number of beds: *20 female*

DESCRIPTION

This is a 20-bed unit for people with a learning disability that also provides care for the elderly. On the day of inspection, there were 15 people on the unit.

REFERRAL

There are no regular admissions to the unit and the unit has a static population. Any admissions are through the consultant psychiatrist. The physical well-being of the patients is looked after by a visiting GP, supplemented by the NCHD. The staff on the unit communicate with family members as much as possible to involve them in the patients' care. The specific level of observation is one-to-one and is initiated by a risk assessment carried out on the patient. There is a key worker system and staff are allocated to groups of patients. The staff work a day on, day off system, so two staff are allocated to the key worker system, one from each shift.

CARE PLAN

The care plans are nurse led; nursing needs are identified and goals and objectives are set. There is no involvement of other disciplines in the care plan. Care plans are reviewed every six months but can be reviewed more often. The only discharge from the unit is to a nursing home.

NURSING PROCESS

The unit uses the human needs model, which is described as mostly appropriate to the needs of the patients. It is implemented by the key worker. There is no formal risk assessment undertaken apart from identifying any patient requiring one-to-one nursing.

North Dublin

ACCESS TO THERAPY

There is no access to clinical psychology or social work. Some of the patients attend the retirement centre which is staffed by nurses. There is access to a behavioural therapist. There is one consultant psychiatrist with responsibility for the patients who carries out regular reviews and also checks the patients when requested. The registrar visits on a daily basis. Medical or surgical consultations are usually facilitated at Beaumont Hospital or on St. Clare's (Unit 12) within the hospital. Patients on the unit have access to a dentist on site and to an optician. A number of patients had an occupational therapy assessment for their seating requirements.

ACCESS TO THERAPEUTIC PROGRAMMES

There is a mixture of activities external to the unit and also on the unit. A number of the patients attend the retirement centre and others carry on activities on the unit.

SECLUSION

There are no seclusion facilities on the unit.

CLINICAL RISK MANAGEMENT

There are policies and procedures in place and these come under the auspices of the Policy Review Committee. Work is being undertaken on a new restraint policy but currently all restraint is signed for, including cot sides and belts. Staff receive training in prevention of violence and aggression, including de-escalation and breakaway techniques. There are a number of in-house courses and mandatory courses which staff undertake and they are also supported in undertaking long courses. The serious clinical incidents are recorded on appropriate forms.

UNIT MANAGEMENT

There are no temporary or long-term transfers to other units. Patients are allowed off the unit accompanied by staff, with one person allowed to go alone. The door to the unit is open. There are four staff nurses and three care staff on duty during the day. It was reported that on occasions staff numbers fluctuated between three and five staff nurses. There was one person on one-to-one nursing. At night there is one staff nurse and one care staff. The unit has a core staff group and uses a central roster for the one-to-one nursing duties. There are three household staff. There is a two week induction for students on the unit but no formal induction for regular staff. Maintenance is provided by the on site maintenance team. It was reported that there is some delay in this process. Visiting times to the unit are flexible. Meals are at set times and there are snacks and drinks provided during the day. There is written information on treatment and therapies but it was reported that this is done verbally. There is a complaints procedure.

RECORDS

The patients' names and ID numbers were not evident on all pages of the medical files. They were legible and tidy however. Entries had the full names and titles of personnel and entries were signed and dated. There were no progress reports from other health professionals. There was a nursing and medical treatment plan. It had dated and signed progress reports. There were regular reviews from the consultant psychiatrist and the NCHD. The nursing files were up to date, tidy, legible and had comprehensive care plans which were regularly reviewed. Medication cards were signed, dated, legible, used generic names and discontinuation of medication was signed and dated.

ENVIRONMENT

This is a 20-bed unit within the main building of St. Joseph's Hospital. There are currently 15 patients in the unit. There is a maintenance programme and disabled access. The décor was of a reasonable standard but some areas need redecorating. There was access to a garden. The bedroom areas afforded as much privacy as possible. There were 15 people in one dormitory. There were curtains around the beds and individual wardrobe space. Toilets and bathrooms were freely accessible and adequate. There was some damp in one area of the bathroom. The dining area

was shared with the unit next door and there was space for one sitting. Some of the patients required assistance with feeding. The lounge area contained comfortable seating. There was TV, a video and radio. The nursing station was situated centrally in the day area. It was of a good size and with adequate space for report writing. There was a telephone system but no IT. The clinical room also doubled as the office and there was appropriate equipment and storage. There was a dedicated staff area for changing and there was also access to a study room. There was adequate storage for patients' possessions.

FÁILTE GROUP HOME

Date of inspection: *22nd November 2005*

Number of beds: *7 male*

DESCRIPTION

Fáilte group home is a two-storey house in the grounds of St. Joseph's Hospital which was opened initially as a day service for patients in Dún na Rí (Unit 11). It was set up to deal with patients usually with challenging behaviour or aggressive behaviour. Patients in this group home may have a forensic history or forensic needs.

REFERRAL

Most patients have come from the hospital or community-based residential services. Patients admitted to this service are generally well known to the community services and community team and are assessed prior to referral. The hospital has no designated acute admission unit. More disturbed patients have traditionally been admitted to Dún na Rí or Dunhaven. A weekly meeting of the community team is held in Swords and referrals are discussed at this meeting.

PROCESS OF ADMISSION

There are policies and procedures throughout the service in relation to group homes and community residences. Residents here have in-patient status and include one certified patient. Since they are admitted here for rehabilitation and specialised intervention it is not used as an alternative to acute admission. A complete nursing assessment is performed following admission based on the human needs Orem model of care and a psychiatric and physical review is conducted every six months. The decision to admit is made by the consultant psychiatrist, along with the nursing staff. The consultant psychiatrist reviews within a week of admission. All patients have a nursing care plan within a couple of days of admission and there is a key worker system in operation.

CARE PLAN

There is no formalised multidimensional assessment or multidisciplinary assessment or care planning due to the absence of an occupational therapy and psychology service. The staff have introduced an updated version of the human needs nursing model of care planning. The staff were introducing individual clinical risk assessment and risk management strategies. The aim is to develop an objective method of risk assessment. The key worker arranges the care plan meetings and the reviews which are conducted every six months. The consultant psychiatrist, NCHD, nursing staff, care assistant and Montessori teachers attend to individual personal plan meetings. If therapy staff are unable to attend, a key worker attends the therapy and checks prior to the Individual Patient Plan (IPP). In the last year, about four patients have been discharged. At the time of inspection there was a planned transfer to Glasmere, Stamullen, or Blackrock Abbey, Dundalk.

NURSING PROCESS

All the residents of Fáilte have an individual plan of care developed from an evidence based framework for the assessment of needs (the human needs model of nursing). The nursing process underpins the human needs model of nursing. Overall, staff endeavour to meet the needs of residents in the unit through the provision of quality, evidence-based practice, delivered in a systematic manner. The key worker system is used for the assessment and formulation of individual care plans (the key worker role can only be undertaken by a registered nurse). In

keeping with Scope of Practice 2000, each key worker is responsible and accountable for the nursing practice incorporated in individual care plans. The key worker is responsible for the implementation, evaluation and further development of care relative to the patients' needs. Nursing care is documented within a standardised individual care folder.

REHABILITATION TEAM

There is no rehabilitation team for the service. However there is a resettlement committee with representatives. Patients in the house have access to advocacy. The consultant psychiatrist reviews the patients frequently. There is an ongoing dispute in the hospital regarding access to a visiting GP service which is deemed to be not satisfactory. GPs attend ad hoc, on request. The NCHDs do not provide routine cover thus no physical examinations had been done in over a year on the patients in the service. Staff numbers in Fáilte are regularly one staff member short.

INVOLVEMENT IN REHABILITATION PROGRAMMES

There was evidence of needs-based individual programmes. Some patients were involved in programmes to move to lower levels of support. Patients attend horticulture, Montessori, swimming, bowling, gym, the multi-sensory room; they also attend Tús Nua, woodwork and the education centre. Some patients are escorted to and from activities and programmes.

CLINICAL RISK MANAGEMENT

There were policies on clinical risk management and individual clinical risk assessments.

There was an alarm on one bedroom that sounded in the nurses' station if the patient attempted to leave the room. All the staff had personal attack alarms. Staff were satisfied with the amount of training available. Training in the assessment and management of substance misuse, nursing management, handling, and control and restraint was provided.

UNIT MANAGEMENT

There are no temporary or long-term transfers from other units and the unit is not used for any other purposes. There are a mixture of intellectual disability trained nurses and registered psychiatric nurses working in the house. There are two staff nurses, a clinical nurse manager and a CNM2 on day duty. At night there is one staff nurse and one care staff. There are two care staff on during the day, one for the kitchen and one who working alongside the nursing staff. Unit rostering applies in the case of the nursing staff. The aim of the house is to provide a home-like environment and a safe and secure environment. There is an emphasis on autonomy. There is a formal process of induction for patients and staff. There are policies in place and procedures present. Students at competency level 3 may be placed here. Formerly, there were patients' meetings but these were stopped as staff felt they were being used for personalised attacks. The consultant psychiatrist manages the waiting list. Two to three patients are moved to lower levels of the support in an average year. As with other facilities in the service, the standard of maintenance was low, the house needed repainting and refurbishment.

HOUSE RULES

Staff were of the view that behaviours can be over-regularised. Concentration is focused on reinforcing positive behaviour. Visiting times are flexible. Patients do not have a front door key. They can lock the bathroom door. They cannot lock the bedroom doors. Some patients may leave unsupervised. Patients are required to check in and out and patients who attend the day service programme are not required to be out during the day. Household staff prepare the meals on site. The patients prepare supper each day and at weekends. Patients can use the kitchen to make drinks and snacks. There are no padlocks on the presses or fridge. Bedtimes are flexible. Patients are not allowed to smoke in their bedrooms. The more disturbed patients tend to get individual rooms. Patients cannot have a visitor stay overnight due to lack of facilities. During the week, patients are required to be up for work at 0900h. Patients' belongings are listed. There is a policy on the financial management of patients' money. Patients attending the day services receive some

money for that in addition to their disability or social services money. All patients receive social services money, the remainder are on hospital comforts allowance. Patients do buy their own clothes from local shops. Patients have free use of the utility room and do their own laundry. Patients cannot access services in the community unaided. Local facilities are within walking distance and there is access to a public transport service.

SERVICE USER INVOLVEMENT

Patients are involved in their care plan informally. One patient has referred himself to behavioural therapy. There was no written information available about the service and the hospital complaints policy is adhered to. One residence has access to advocacy services. Patients who spoke to the inspector commented that they liked Fáilte. They were involved in the Christmas play, which they perceived as an opportunity to meet up with families, carers and friends.

RECORDS

Documentation of nursing care and care plans is subject to regular audit. The five areas covered in the human needs model of nursing are physical needs, safety and security, affiliation needs, dignity and self-esteem, and self-actualisation. Each patient has a nursing information sheet that gives details of the key worker, demographic details, personal, medical and psychiatric history. Nursing staff complete reviews of the care plan, and the individual programme plan that covers problem, goal, associated needs, deficits, plan, person responsible and review date.

Records were legible and tidy. In the medical notes, the patients' names and ID numbers were not on all pages. Entries did not have full names and titles of personnel although the entries were dated and signed. There were no progress reports from other health professionals. The psychiatric notes contained a six-monthly psychiatric review by the NCHD and a note from the consultant psychiatrist every six months. Despite the regular attendance by the consultant psychiatrist, there was little evidence of regular consultant psychiatrist review of patients. The progress report and nurses' notes contain a section for review of identified problem. There is a separate evaluation sheet for the care plan. Nursing notes did not have full name and title and entries were signed and dated. No patient was currently on a self-medication programme. The prescription card index was satisfactory.

ENVIRONMENT

There is no regular ongoing maintenance programme in place. Maintenance is provided by the hospital maintenance department. In general, the house needed refurbishment. It had not been painted or done up since it was originally occupied. It needed repainting and the floors needed to be redone. It was open and had a pleasant home-like atmosphere. This was a 7-bed residential facility, sleeping accommodation consisting of three single and two double rooms, all located upstairs. There was one toilet, one bathroom and one shower area located upstairs specifically for patients' use. The ground floor consisted of a sitting room, kitchen/dining area, office, utility room, storage area and two toilets. The sitting room was comfortable with two couches and two single chairs with a TV, DVD and video, newspapers and comfortable furnishing. There were a further three storage areas along with laundry facilities located in a separate building outside.

The office downstairs had a computer. There was a computer for patients to use in the hall.

FERN LODGE UNIT

Date of inspection: *22nd November 2005*

Number of beds: *7 integrated, 4 male, 3 female*

DESCRIPTION

Fern Lodge is described as an open two-storey unit in the grounds of St. Ita's Hospital. There are no patients in the unit detained subject to the Mental Treatment Act 1945 and the age range of patients is from 21 to 50 years. The unit serves as an admission unit, a rehabilitation unit and also provides continuing care. There are two or three patients who are expected eventually to move to lower levels of supervision.

North Dublin

REFERRAL AND PROCESS OF ADMISSION

Some of the patients in this unit are long-stay patients. There had been two admissions in the previous week, one from another service and one an internal transfer. The staff are notified of an admission by the consultant psychiatrist. All admissions are seen by the NCHD and reviewed by the consultant psychiatrist within a few days of admission.

CARE PLAN

The nursing care plan is based on the Maslow Hierarchy of Needs and it was felt by staff to be appropriate to this patient group. Care plans are reviewed every few months. In some cases, the care plan is agreed with families during a care planning meeting. Patients are also assessed using a behavioural assessment based on adaptive behavioural scales, which also contains a clinical risk assessment.

NURSING PROCESS

There are three nursing staff on duty during the day and one nurse on duty at night. There is a primary nurse system in operation and good continuity of staff. There are no specific observation levels in operation.

ACCESS TO THERAPY

There is no psychologist, social worker or occupational therapist in the service. There are two behavioural therapists who see patients on request. There are no regular team meetings with the consultant psychiatrist on the unit. Consultant psychiatrists attend the unit once a week and the NCHD attends the unit approximately every second day. Physical needs of patients are dealt with by a visiting GP but there have been no routine physical examinations for over 18 months.

ACCESS TO THERAPEUTIC PROGRAMMES

Patients attend the day services where there are a number of activities available for patients away from the unit. Each patient is referred for particular programmes such as education, Montessori education, gym, multi-sensory therapy and art therapy. Other activities such as outings, walks, swimming and horse riding are also available. Four patients are retired and usually spend their time in the unit.

SECLUSION

There is no seclusion used.

CLINICAL RISK MANAGEMENT

The service policies were available on the unit. Staff had access to training in crisis prevention and other courses run by the school of nursing. No restraint was used and staff carried personal alarms.

UNIT MANAGEMENT

There is a monthly management team meeting with nursing staff on the unit. There are no short-term transfers due to bed shortages in other parts of the service. There is one household staff in the unit. A few patients go home at week-ends. There is no CCTV on the unit. Bedtimes are flexible. Food is cooked on the premises and patients help with the cooking and shopping. At weekends, patients may get takeaway meals if they choose. Patients buy their own clothes accompanied by staff.

RECORDS

The clinical files showed evidence of regular psychiatric review. However there had been no physical examinations for at least 18 months. There was no physical examination record available in the file of a patient admitted the previous week. Medication sheets were legible, signed and dated. Discontinuation of medications was signed and dated. The care plans were up to date.

North Dublin

ENVIRONMENT

The unit was located in the grounds of the hospital. It had a pleasant homely environment with plenty of pictures, plants, ornaments and personal possessions. The bedrooms were mainly single and double rooms; there was one treble room that was quite cramped. The bathroom and shower were too small but renovations are planned to rectify this and to provide another shower downstairs. The sitting room and dining area were pleasant.

HILLVIEW

Date of inspection: *22nd November 2005*

Number of beds: *19 female*

DESCRIPTION

Hillview is a 19-bed female care of the elderly unit. It is located in a single-storey building on the grounds of the hospital. All patients on the day of inspection were of Voluntary status under the 1945 Mental Health Act. Two patients were Wards of Court. The age profile was from 51 to 83 years.

REFERRAL

Referral to the hostel is from community residences. The last admission was in May 2005.

PROCESS OF ADMISSION

A consultant psychiatrist makes the decision to admit a patient to this unit. A full examination is completed and the case notes follow the patient. The consultant psychiatrist reviews the patient regularly and all medical issues are referred to the GP. Each nurse has two patients according to the key nurse system.

CARE PLAN

The care plans are linked to the nursing care plan and medical treatment plan. There is no multidisciplinary team care plan in place.

NURSING PROCESS

The nursing assessment is based on Maslow's assessment of need. Each patient has a detailed assessment using this model. A large number of patients have physical health problems. A new system of clinical risk assessment is being introduced. The nursing staff operate a key nurse system.

ACCESS TO THERAPY

The unit staff can access the GP and chiropodist by referral. The consultant psychiatrist and NCHD visit regularly. There is access to a dental service on site in the hospital.

ACCESS TO THERAPEUTIC PROGRAMME

Nine or ten patients attend the day services on site and are transported by minibus. Others are facilitated to use the hospital canteen or take walks on the grounds. A small number of patients have regular trips home to families.

ECT

No patient is in receipt of ECT at the time of inspection.

SECLUSION

Seclusion is not in use on the unit.

CLINICAL RISK MANAGEMENT

The hospital-wide policies and procedures are available on the unit. Cot sides are in use to prevent falls at night and this is recorded in the restraint register. The restraint policy is currently under review. The staff are offered training courses and in-service training on mandatory training. All incidents are recorded and reported in accordance with the HSE Northern Area policy.

North Dublin

UNIT MANAGEMENT

The unit is self-staffing. There is a CNM2 and four staff nurses and four care staff on duty during the day. At night there are two staff nurses and two care staff on duty. The external door is locked and all patients are accompanied off the unit. There is no waiting list for admission and it was reported that two patients could move to alternative forms of accommodation. Meals are prepared in the hospital and delivered to the unit and all diets are accommodated. Visiting times are flexible.

SERVICE USER INVOLVEMENT

Oral requests for information are provided by staff. Complaints are rare and dealt with at a local level. The advocacy service does not visit the unit.

RECORDS

The psychiatric and medical notes were separated. The notes reviewed were in order and showed evidence of regular reviews. The records did not have space for a patient identifier. All notes were signed but there was no corresponding signature bank. The nursing notes were in order, legible and showed evidence of regular reviews. There was a nursing staff signature bank in place. The nursing staff were introducing comprehensive new written procedures that would assist staff in external hospitals looking after a patient with intellectual disability. There was also evidence of assessment by the behavioural nurse therapist in some charts. The medication sheets were legible and in order on the day.

ENVIRONMENT

Hillview is a single-storey building, divided into three distinct areas. Each area was a different colour and had sleeping, day and bathroom facilities. Attempts had been made by the staff to improve the environment using pictures and modern duvet covers. Some bed areas had individual personal effects. There was an internal smoking room and external courtyard. The nursing staff had requested specialised seating for two patients, repainting and also bed curtains to aid privacy. All equipment for hoisting patients was in place.

ST. CLARE'S UNIT

Date of inspection: *22nd November 2005*

Number of beds: *19 integrated*

DESCRIPTION

St. Clare's unit is a 19-bed unit located on the grounds of the main hospital. It is also known as the infirmary and serves a dual purpose to provide medical care for patients following medical or surgical procedures and to provide ongoing care for patients who, in addition to their intellectual disability, have extensive physical or medical needs. The unit is locked and all patients are Voluntary status.

REFERRAL

There are two distinct pathways for admission. The unit accepts referrals for patients who are being discharged from other hospitals and require a period of ongoing medical attention. There is a core group of 12 patients resident in the unit.

PROCESS OF ADMISSION

Patients are referred by the consultant psychiatrist in conjunction with nursing staff based on clinical need. Length of stay varies from an overnight stay to a number of weeks. The case notes follow the patient. Patients are reviewed medically by a visiting GP. The consultant psychiatrist and NCHD review psychiatric needs.

CARE PLAN

Care planning centres around a detailed nursing assessment, psychiatric review and GP medical reviews.

NURSING PROCESS

There is a mixture of nursing models in operation, Roper Logan Tierney and Maslow's assessment of need. An initial assessment is completed, each patient has an individual care plan and goals are reviewed as required.

North Dublin

ACCESS TO THERAPY

Each patient has access to nursing, GP and psychiatric staff. The consultant psychiatrist visits regularly. The GP visits daily Monday to Friday and an out-of-hours service is provided by the NCHD. There is access to a chiropodist by referral. The unit has a number of highly dependent patients, some on PEG (tube) feeding. There is no access to physiotherapy or to speech and language therapy. The unit staff have established links with staff in Beaumont hospital and wound management nurse. There is no access to occupational therapy or clinical psychology, or to a social worker.

ACCESS TO THERAPEUTIC PROGRAMME

Given the core purpose and age profile on this unit, only four patients attend the day services programme on site. An annual report is provided to the staff on individual performance.

ECT

There is no ECT administered on this unit.

SECLUSION

There is no seclusion room on the unit.

CLINICAL RISK MANAGEMENT

There is a folder of policies and procedures that have been signed by the core management team. All staff carry alarms. The main clinical risk areas are risk of falls, wound management and behaviour management. The use of cot sides and body suits and other posy belts are documented in the restraint register, which was up to date. There is one patient who is restrained for set periods, using a straitjacket. This is kept to a minimum and other techniques are in place to manage difficult behaviour. This patient has a single room and access to a partially padded room. Both rooms are open at all times. Staff are continuously offered refresher courses, which are provided in-house on mandatory training courses. They also seek information from supplier representatives on pressure care management and wound management. All clinical incidents are reported and recorded as per the hospital procedure.

UNIT MANAGEMENT

The unit is self-staffing for nursing staff. There is one CNM2 and four staff nurses on day duty and two staff nurses at night. The care assistant staff are rostered centrally. There are three care assistants on day duty and access to one care assistant at night. Some staff wear uniforms. Some nursing staff are trained in taking bloods. The upkeep of the unit is the responsibility of the hospital maintenance staff. Visiting hours are open. Meals are prepared in the main hospital. Some patients require assistance with feeding and soft diets. Meal times are at set intervals.

SERVICE USER INVOLVEMENT

Some residents ask for information about medication, especially those in the unit for short periods. Complaints are minimal and dealt with at a local level. An advocacy service does not visit the unit.

RECORDS

The medical and nursing notes were separate. The medical notes were subdivided into psychiatric notes and medical (GP) notes. There was evidence of regular and ongoing review by the medical teams. There was no evidence of recent six-monthly physical examinations. The continuation sheets did not allow for a patient identifier on each page.

The progress notes were signed. There was no medical staff signature bank. The nursing notes were complete and up to date. The nursing staff had a signature bank. The medication sheets were in order.

ENVIRONMENT

St. Clare's is a single storey building located on the grounds of the hospital. It was divided into three distinct areas. Each area was the same, containing

sleeping areas, day room and bathroom facilities. There were a number of single rooms and dormitory rooms. There was one dining room. Staff had made efforts to improve the environment with pictures of residents, mirrors and paintings. The environment was in need of repainting. The staff had requested specialised chairs and a tracker hoist (currently on loan) to improve the care of patients and reduce the risks to staff.

ST. JOSEPH'S UNIT

Date of inspection: *22nd November 2005*

Number of beds: *20 integrated, 10 male, 6 female*

DESCRIPTION

St. Joseph's Unit is made up of a row of six terraced single-storey houses. Each house is independent, with its own front door. There is an administration area in one house, and one house is used as a dining and sitting area for all the residents. The residents range in age from 30 to 70 years. On the day of inspection, there were 16 residents. There is capacity for 20 residents. A respite service is offered by St. Joseph's Unit.

REFERRAL

Referrals come via two pathways. Admissions generally come from community services or community residences to the consultant psychiatrist. Admissions for respite are arranged through the community services and coordinated by the consultant psychiatrist and nursing staff.

PROCESS OF ADMISSION

Residents coming from community residences are admitted following assessment. The notes follow the resident. The consultant psychiatrist reviews each resident.

CARE PLAN

The care plans are divided into a nursing care plan and a medical treatment plan. All residents attend a day service on site or with an external agency. A report is provided annually on progress.

NURSING PROCESS

The Roper Logan Tierney model of nursing is in use. Each resident has a folder, and progress notes are written as necessary.

ACCESS TO THERAPY

Residents have access to intervention from medical, nursing and care staff. A chiropodist visits regularly and records notes. There is no access to an occupational therapist, social worker or clinical psychologist.

ACCESS TO THERAPEUTIC PROGRAMMES

The majority of residents attend day services on site. A small number attend services off site and are transported to the service. One resident is self-employed. Staff on the unit do not attend services with residents. Residents return for meals during the day.

ECT

No resident was receiving ECT at the time of inspection.

SECLUSION

There are no seclusion facilities.

CLINICAL RISK MANAGEMENT

The unit is governed by the hospital policies and procedures. Each resident is fully mobile and can leave the area unaccompanied. Each resident has a

key to his or her own house area. Restraint techniques are not in use. Staff are offered in-service training and refresher courses on a regular basis. Incident reporting is in accordance with the HSE Northern Area policy.

UNIT MANAGEMENT

The unit is self-staffed. There is one CNM2, two staff nurses and two care assistants during the day. At night there is one staff nurse and one care staff on duty. Meals are provided at set intervals from the hospital kitchen. The hospital maintenance staff delivers a maintenance programme. The nursing staff manage money for most of the residents, keeping records. There is no financial policy in place to govern this procedure. It was reported that visitors are frequent and some residents go on leave to their families.

SERVICE USER INVOLVEMENT

The advocacy service does not visit the unit. There is no community meeting in place. It was reported that residents do not ask for information on treatment and rarely complain.

RECORDS

The medical notes are divided into psychiatric notes and medical notes. The notes reviewed showed evidence of regular psychiatric review. There have not been any recent physical examinations completed. The nursing notes were in separate folders. Progress notes were written as required. There was a signature bank available for nursing staff only. The medication charts reviewed were in order.

ENVIRONMENT

The six terraced single-storey houses were exactly the same in layout and design. The houses were old and the décor and the furniture was dull and lacking in any homely personal affects. The communal sitting area was long and narrow. Each house had a single room, two double rooms and a sitting area.

ST. VINCENT'S UNIT

Date of inspection: *22nd November 2005*

Number of beds: *8 integrated, 4 male, 4 female*

DESCRIPTION

St. Vincent's Unit is in the grounds of St. Ita's Hospital and all residents have an intellectual disability. It is an open unit and all residents are on Voluntary status and have been up to 30 years in the in-patient service. The age range is between 34 and 60 years. The residents are semi-independent in looking after their personal needs. There is a strong emphasis on providing a home for the residents and the unit operates more as a 24-hour supervised hostel rather than an in-patient unit.

REFERRAL / PROCESS OF ADMISSION

The population of this unit is static and there have been no admissions for a number of years. The last admission was an internal transfer from another unit. There are no further admissions planned to this unit and it is expected that it will eventually close.

CARE PLAN

The care plan is nurse led and based on the Maslow Hierarchy of Human Needs. The care plans are reviewed regularly. Two residents have successfully completed a weight reducing programme as part of their care plan and one resident is on a communication programme for language signing. It is hoped that one resident may be discharged to a lower level of support in the future.

NURSING PROCESS

There are three nursing staff on duty during the day and one staff nurse on duty at night. There is a primary nurse system in operation and there is good continuity of staffing.

ACCESS TO THERAPY

There are no psychologists, social workers or occupational therapists in the service. The consultant psychiatrist attends the unit every two weeks and the NCHD visits most days. There is access to a behavioural therapist on referral. A GP is available on request.

ACCESS TO THERAPEUTIC PROGRAMMES

There are a number of activities available for residents off the unit in the grounds of the hospital. Each resident is referred to the day services for particular programmes such as Montessori education, gym, multi-sensory therapy, domestic skills and art therapy. Other activities such as outings, walks, bowling, swimming and horse riding are also available. The emphasis is on residents choosing which activity they wish to attend.

SECLUSION

There is no seclusion carried out on the unit.

CLINICAL RISK MANAGEMENT

The service policies were available on the unit. There is a Policy Review Committee which is in the process of reviewing policies. The staff carry an alarm and are contactable through a pager system. There are no mechanical restraints used on this unit. Staff are trained in crisis intervention techniques. The service has a new system of reporting serious incidents.

UNIT MANAGEMENT

There are monthly unit meetings where management issues are discussed. These meetings are attended by nursing staff. The unit receives its own budget of €205 for food and €65 for social activities. The menus are planned with the residents who accompany the staff when shopping for food. Residents also assist in cooking meals. The kitchen is open to residents for short periods during the day and some can make tea, coffee and toast. The unit has recently received a computer. Each resident goes on holiday once a year. Residents can come and go from the unit as they wish and bedtimes are flexible.

SERVICE USER INVOLVEMENT

Residents interviewed said that they liked the unit and were happy there. The ability of residents to read written information was limited. There is a friends and parents support group that meets with management regularly.

RECORDS

The clinical files show evidence of regular six-monthly psychiatric reviews. However, in common with most of the service there have been no physical reviews done for 18 months. This is unacceptable. The care plans were up to date and the medication sheets were satisfactory.

ENVIRONMENT

St. Vincent's Unit is located in the grounds of the hospital. It is a two-storey building which consists of two adjoining houses. The unit is in need of re-decorating but there was a homely atmosphere. The bedrooms consisted of double and single rooms. There was a sitting room adjoining a dining room and kitchen. There was also a nurses' office. Residents had a number of personal possessions in their rooms and around the unit.

ST. JOSEPH'S INTELLECTUAL DISABILITY SERVICES

WOODLAWN, LUSK

Date of inspection: *23rd November 2005*

Number of beds: *9 integrated, 4 permanent, 5 respite care*

DESCRIPTION

This is a community residential, respite and day service facility for young people with a learning disability who exhibit challenging behaviour. It is a 9-

bed unit, with five beds for respite care. There are four permanent residents. Two people who use the service are deaf.

REFERRAL

The source of referral is the central support office in Swords. There is a team meeting to discuss referrals and subsequent visits are organised. Parents are involved in the process and are given the opportunity to meet with service providers and also to visit the unit. Following this the young person will visit the unit alone and a gradual admission process begins.

PROCESS OF ADMISSION

There is a comprehensive assessment process and the main criterion for admission is to engage people in services. There is both an educative and rehabilitation role. A number of young people are admitted for respite care. On admission, a full medical assessment is carried out and also a psychology assessment, nursing assessment and a behavioural therapy assessment. A physical examination is undertaken by a GP and a detailed collateral history is obtained. Decisions to admit a young person to this unit are made by the team. There is a strong emphasis on working with the resident and their family. The clinical nurse specialist meets with the family at the beginning of the process and this is followed on by other staff. The whole philosophy of the unit focuses on the person-centred care plan (PCP) which is derived from a meeting attended by all significant parties including parents. There is a key worker system in place.

CARE PLAN

The care plan is a multidimensional assessment that identifies need, and also prioritises the need. There is involvement of appropriate people in meeting the needs; goals and objectives are identified and delegated to members of the team. Care plans are reviewed formally at monthly meetings. The family attend the meetings and receive minutes and are involved in the process. When people are ready to leave the unit there is a comprehensive discharge policy put in place.

NURSING PROCESS

The PCPs are based on the human needs model and are appropriate to the needs of the residents. The implementation of the care plans is based on a very strong team emphasis. There is no formal risk assessment and this is identified as an area in need of development. There is a key worker system in place.

REHABILITATION TEAM

Some of the residents have access to a psychologist in a training scheme they attend. Other residents have access to St. Michael's House for initial assessments. There is no occupational therapy input to the unit. Most of the residents already have social worker input and this continues during their stay at Woodlawn, up to the age of 18. There is also access to a speech and language therapist and a teacher. The teacher in the unit is also an educational psychologist. There is one consultant psychiatrist who has responsibility for the residents in the unit and she reviews on a weekly basis. The physical needs are met by a GP and there is a good relationship with the GP surgery. There is a sign language teacher with input to the unit. Due to the fact that two of the residents are deaf all of the staff are qualified in signing.

INVOLVEMENT IN REHABILITATION PROGRAMMES

The main emphasis of the programme is on promoting independent living and to re-establish education, as a number of the residents have had difficulties in their original schools. A number of the residents attend day services off site and there is a full programme within the unit.

CLINICAL RISK MANAGEMENT

The area of clinical risk management and the individual risk assessments need to be developed. Any serious incidents are reported on appropriate forms and sent to the Assistant Director of Nursing, and there is appropriate follow up.

North Dublin

UNIT MANAGEMENT

There are no temporary or long-term transfers from the unit. The staff in the residence are qualified nurses and care staff. There is a strong emphasis of team working within the unit. During the day there are two nurses on duty and two or three care staff. There is a manager who works Monday to Friday and a teacher who works five days a fortnight. During the night there is one nurse and one care staff and it was reported that extra staff can be obtained if needed. There were also student nurses on placement. The unit is self-staffing although extra staff are provided via a central rostering system in St. Joseph's Hospital. There is a formal process of induction for residents and staff. Each resident has a communication book which is accessed and written in by family, activity centres and staff within the unit. This ensures that any issues are recorded and dealt with. Maintenance is provided by the St. Joseph's Intellectual Disability Service maintenance team in Portrane.

HOUSE RULES

There are general rules within the unit pertaining to no alcohol or drugs and to generally respect other people's space and property. Visiting times to the unit are flexible. Residents can lock their bedroom doors and staff have an overriding key. Residents are allowed to leave unsupervised. There are a number of group activities and social outings which staff and residents attend. Meals are prepared on site and the residents are involved in the preparation of meals. Residents have access to the kitchen for snacks and drinks between meals. Residents are encouraged to go to bed early as they have an active day. All rooms are single. The residents are expected to be up at set times during the week for specific activities.

The residents do not manage their own finances. There is a policy in place to oversee the management of money, or parents take responsibility. The unit is fully integrated with the local community. A number of the residents attend special schools as part of their rehabilitation or education programme and also residents attend some work training schemes. None of the facilities are within walking distance and there is a busy road close to the unit. There is transport available within the service. There are a number of facilities and activities available to the residents on site, incorporating group and individual sessions.

SERVICE USER INVOLVEMENT

There is resource information available. The residents who are over 18 have the right to vote. There is a complaints procedure in place and also numerous sources of obtaining residents' and families' views of the service.

RECORDS

The residents' name and ID number were evident on all pages of the files. All entries had the full names and titles of personnel and were signed and dated. The PCP is held at least annually and all parties involved attend a meeting and provide a review. Treatment plans were evident in the notes and the frequency of consultant psychiatrist review was regular. The nursing files were combined with the medical and other disciplines and care plans were prioritised and evaluated. This was a very comprehensive system to ensure the needs of the residents are met. The medication cards were all signed, dated, legible, used generic names and the discontinuation of medication was signed and dated.

ENVIRONMENT

This was a very pleasant single-storey unit which has a regular ongoing maintenance programme. The hygiene and décor of the unit were of an excellent standard. The furniture purchased for the residents was of a very high standard. All residents had single rooms that were of good size and could be personalised by the resident. The unit contained a number of single rooms, two lounges, a kitchen, dining room, classroom and multi-sensory room, sufficient toilets and bathrooms, two offices, a laundry room and a night nursing station.

STAFF TRAINING

There is training available for staff and this is a varied programme focused on the child and also mandatory training. There is support for long courses both in time and finance.

AVOCA RESIDENCE, DONABATE

Date of inspection: *23rd November 2005*

Number of beds: *5 integrated, 4 male, 1 female*

DESCRIPTION

Avoca is a residence with 24-hour nursing staff supervision located on the edge of Donabate village. It was opened in September 2004 and is home to five residents. The residents range in age from 24 to 74 years. The residence consists of two two-storey modern houses with the downstairs dividing wall has been removed. The premises are rented from a private landlord.

REFERRAL

The residence is under the clinical direction of a consultant psychiatrist. There are two distinct referral pathways. Permanent residents are referred from the resettlement team in the hospital. Referrals for respite care are booked through the central support office in Swords. There is a weekly team meeting where referrals are discussed.

PROCESS OF ADMISSION

All referrals are discussed at the resettlement team meeting and patients are matched to residences that best meet their needs. A full nursing assessment is completed prior to admission and families are involved as much as possible. The patient is gradually introduced to the house. A key nurse is allocated from the time of admission.

CARE PLAN

The resident can access the consultant psychiatrist through the weekly outpatient clinic. Out of hours review is provided by the NCHD on call to St. Joseph's Hospital. Each resident has a yearly individual programme-planning (IPP) meeting to which family members are invited. All residents are new to the residence and there have been no discharges to lower levels of accommodation as yet. There is open and frequent communication with families and service providers in work and leisure environments.

NURSING PROCESS

Each resident has a human needs model assessment completed and care goals identified. The care goals are reviewed every three to four months. The initial assessment was completed after the residents had settled into the house.

REHABILITATION TEAM

There is no dedicated rehabilitation team. Rehabilitation is provided by the nursing, care assistant and medical staff. There is no access to occupational therapy, a social worker, or clinical psychology. A reflexologist visits the house frequently and provides individual sessions. The residence is staffed by one CNM2, one staff nurse and one care assistant by day. At night there is one staff nurse on duty.

INVOLVEMENT IN REHABILITATION PROGRAMMES

Each resident attends a day service according to his or her needs. A number of residents attend day services in St. Joseph's Hospital. Two residents attend programmes provided by Eve Holdings Limited and Prosper Fingal Limited. Residents are also encouraged in other activities or hobbies; examples include horse riding, swimming and bingo. The residence applied for a health promotion grant in 2004 and successfully developed the garden area with the grant. This was a joint project between staff and residents. It is hoped that some residents will access open supported employment in the future.

CLINICAL RISK MANAGEMENT

Clinical risks are documented individually according to physical and mental health needs. All incidents are recorded and reported as per HSE Northern Area policy.

UNIT MANAGEMENT

Nursing and care assistant staff manage the residence. Staff self-roster and are consistent. The ethos and focus within the house is on individual development and quality of life. Maintenance is provided on request from the hospital Maintenance Department.

HOUSE RULES

There are some unwritten house rules decided by the residents and staff. A number of residents have front door keys. The majority of residents can leave the house unsupervised, but let staff know where they are going. Meals are prepared on site by staff and residents. Residents assist with household chores based on ability. A number of residents can independently make small snacks. The kitchen is open and is accessible by residents. Accommodation is located upstairs. All bedrooms are single rooms. There are no set bedtimes at the weekends. Residents are not independent in money management. Currently no resident is paying rent. Residents can manage a daily allowance. Each resident has a post office account and is assisted in its use by a staff member. Residents shop independently for clothes if they are able, otherwise assistance is provided. The residents have integrated well into the neighbourhood and community. Some access buses and trains independently. The house also has a minibus.

SERVICE USER INVOLVEMENT

All residents have been registered to vote. Residents are encouraged to access health initiatives. Community meetings are informal and issues of general interest are discussed at meal times or individually.

RECORDS

The chart is divided into six sections: identification, database information, assessment, care plan evaluation, nursing progress notes, and medical notes. GP records are maintained by the GP. The notes reviewed were in good order, tidy and easy to follow. There was evidence of regular medical review. No resident is currently self-medicating. The medication sheets were in order. The chart of the resident in respite care contained no review by the consultant psychiatrist.

ENVIRONMENT

The residence was composed of a pair of two-storey modern houses. The connecting wall downstairs had been removed. The house was very homely with a kitchen-cum-living room and sitting room downstairs. Every effort had been made to personalise individual rooms and record celebrations through photographs. The garden was very pleasant and was also used for smoking. There was no internal smoking area. All single bedrooms were located upstairs. This may become a problem or a challenge as residents get older. The two bathrooms had a bath with shower overhead. Again, this may become an issue in the future. There was no downstairs toilet or shower area.

STAFF TRAINING

Staff are offered regular training opportunities for mandatory courses. They also source relevant literature from the Internet. The residence has a computer and Internet access. Students from DCU's Intellectual Disability Nursing course are facilitated.

GLEBE RESIDENCE, MALAHIDE ROAD

Date of inspection: *22nd November 2005*

Number of beds: *6 female*

DESCRIPTION

Glebe House is a residence with 24-hour nursing staff supervision located along a busy road near Malahide. It caters for six female residents with moderate to severe intellectual disability. The age range is between 29 and 65 years, with five residents over the age of 50 years. The emphasis is on continuing care and the residence is regarded as the residents' permanent home.

North Dublin

REFERRAL / PROCESS OF ADMISSION

Apart from one admission two years ago, the population of the residence is stable and no resident is being prepared for discharge.

CARE PLAN

The current care plan is the Maslow Hierarchy of Human Needs and this is reviewed every three to six months. However a new individual care plan is currently being introduced and will be operational in 2006. Baseline assessments are currently being carried out. It is envisaged that all professionals involved with each individual resident will be involved in her care plan.

NURSING PROCESS

There is one nurse and one care assistant on duty during the day and one nurse on duty at night. There is good continuity of staff and a key worker system is in operation.

REHABILITATION TEAM

There are no social workers, psychologists or occupational therapists in the service. Residents may attend the outpatients department. There are no team meetings in the residence. Residents attend a local GP.

INVOLVEMENT IN REHABILITATION PROGRAMMES

All residents attend a day centre in Lusk and staff sometimes accompany them to the centre. Activities include games, cookery, outings, and relaxation.

UNIT MANAGEMENT

All meals are cooked in the residence and shopping is done by staff members. Due to their intellectual disability, the amount of input by the residents to maintaining the residence and cooking is minimal although one or two do help with some chores. Clothes are bought by the staff but residents are involved where possible. There are no policies specific to the residence but the service policies were available. A computer had been delivered recently but needed to be connected.

HOUSE RULES

There are no written house rules. Bedtimes are flexible. Residents do not have access to any keys. Residents have their own bank accounts and receive weekly statements. Withdrawals from the bank are carried out by individual residents accompanied by staff. The residents have a good relationship with their neighbours, who visit the residence.

SERVICE USER INVOLVEMENT

Due to the level of intellectual disability residents' involvement in their own care is minimal. However efforts are made to involve families in residents' plans of care and progress.

RECORDS

The medicine sheets accompany the residents to the day centre and were not available for inspection. The clinical files showed no evidence of regular reviews. The nursing notes and care plans were up to date.

ENVIRONMENT

The residence was very homely and comfortable with a lot of photographs and personal possessions. There were two single rooms and two double rooms and each resident has an abundance of personal possessions. The sitting room was comfortable. The combined kitchen and dining room were far too small and there were plans to move the laundry area to the garage and extend the kitchen into the utility room. Unfortunately there were a large number of unfinished maintenance jobs around the residence, for example: plastered but unpainted walls, areas where wallpaper had been stripped but not replaced, and unfinished renovations to the shower and toilet.

North Dublin

CLONMETHAN LODGE, OLDTOWN, CO. DUBLIN

Date of inspection: *23rd November 2005*

Number of beds: *30 integrated*

DESCRIPTION

Clonmethan Lodge is a complex of five 6-bed residences and day services located in Oldtown, which is eight miles north west of Swords in North County Dublin. Clonmethan Lodge was developed to meet the specific needs of people with an intellectual disability who exhibit varying degrees of challenging behaviour. The opening of this complex was designed to facilitate the move from a more institutional type setting to a more community style of living in keeping with the principles of normalisation.

REFERRAL / PROCESS OF ADMISSION

All residents in this service have come from St. Joseph's Hospital and have had challenging behaviour as a feature of their condition. Assessments prior to transfer were conducted. All residents were selected via the resettlement committee. The resettlement consultant and consultant psychiatrist with overall responsibility for Clonmethan Lodge made the decision regarding acceptance into this facility. Families were communicated with prior to the transfer into this service.

CARE PLAN

There is no formal multidisciplinary assessment or care planning process.

NURSING PROCESS

The Orem human needs model of care is in use. All residents are involved in care plans and the families are very involved.

REHABILITATION TEAM

There is no psychologist, occupational therapist or social worker available. A speech and language therapist has provided a service for some months each year. The consultant psychiatrist visits regularly. All the residents are registered with a GP. One of the two St. Joseph's Intellectual Disability Service consultants is responsible for this service.

There is a key worker system in the service. There have been difficulties regarding the GP service but a twice-weekly GP service commenced in the month prior to inspection. The GP also conducts the six-monthly physical examinations. This is very much a nursing-led service.

INVOLVEMENT IN REHABILITATION PROGRAMMES

Residents are not involved in programmes to move to lower levels of support but they do attend day services in the day services building programme. Sometimes they attend with the staff, sometimes staff come from the day services building to bring them to this programme.

The day services were established in 2002. It was envisaged that these would be open to other community members. However currently it caters for the 30 residents in Clonmethan Lodge. Staffing consists of a day service coordinator, a Montessori teacher and two care assistants. Three staff there work from 0930h to 1700h. An IT teacher is provided by County Dublin VEC twice weekly and there is a voluntary art facilitator. The services of a PE instructor and a horticulturist would be of immense benefit to the service. The philosophy of the day service is to provide a comprehensive holistic, educational programme appropriate to the individual needs of the service users.

The day service is located in a beautiful purpose-built multi-function building that has computer rooms, games rooms, table tennis tables, indoor bowls, In addition, there is a multi-sensory room, rooms for living skills, a Montessori classroom, gymnasium, assembly PE hall, computer area, art room and horticulture.

Weekly movies are shown on campus and there is participation by Le Chéile computer integration programme. There are sessions in music and drama, football, weekly bingo, speech therapy, seasonal parties, and quarterly mass and Christmas carol services There are outings to Croke Park, soccer matches and the theatre and there is annual participation in the Christmas concert in St. Ita's

Hospital. On the day of inspection, preparations were ongoing for *The Wizard of Oz*.

CLINICAL RISK MANAGEMENT

There was evidence of policies on clinical risk management. As mentioned, an individual clinical risk assessment is conducted. Serious incidents are audited using the standardised incident reporting mechanism. Of concern is the use of the safe room in two of the five houses. A safe room policy has been drawn up with respect to this and a safe confinement record form is maintained. Fifteen-minute observation is mandatory while residents are in the safe room. The policy in relation to this is known as the "Procedure for the Use of a Safe Room as a Treatment Intervention for a Disturbed Resident – CRO1". This has been submitted to the hospital ethics committee. This is not documented in a seclusion register.

UNIT MANAGEMENT

There are no temporary or long-term transfers from other units to this service. The skill mix is care staff along with nursing staff. There are two nursing staff – occasionally three – on day duty in each house and one at night. There are usually two care staff on during the day and one at night. There are two household staff per house. There are policies and procedures present and a dress code. There was no waiting list. As with other components of the intellectual disability services, the waiting list is managed by the resettlement committee. One resident was re-admitted to St. Ita's in the last year. The hospital provides maintenance. This is an ongoing issue for the service in that there is no ongoing capital or maintenance programme. Staff stated that there is a need for an on-site janitor or maintenance man. Contract workers attend to the garden.

ETHOS

The aim is to create a home-like friendly environment with individualised care in keeping with the principles of normalisation.

HOUSE RULES

Staff prepare meals on the unit. Residents in the house that the inspector visited were not involved in meal planning and shopping due to the level of disability. Residents are not required to go to bed at set times. They usually do so, when the night staff come on duty. They are not allowed to smoke in bedrooms. All the rooms were single. Residents may not have a visitor stay overnight. Residents are not required to get up at set times during the weekend or on week days. Belongings are not listed. Residents have their own wardrobes. The key worker goes shopping with the resident. Residents do not manage their own finances. There is a policy on financial management of residents' money. Each resident has a post office account. Residents are not independent enough to access their own money as required and money is collected by the staff. Each house has a social fund for trips. Residents do not pay any rent for upkeep. Residents buy their own clothes in the local shops. They do not have free access to the utility room or the kitchen. Residents were not able to access services in the community unaided. Local facilities are sparse and not within walking distance. Each house has a vehicle for transport.

SERVICE USER INVOLVEMENT

There is a hospital policy on complaints that is adhered to. Residents or carers' opinions are not formally sought, though families are very much involved in the whole process. The staff have meetings in each house in the day room at which residents may be present. The Assistant Chief Nursing Officer has endeavoured to introduce advocacy services to this facility.

RECORDS

Many of the residents have the adaptive behaviour scales for children and adults completed. Part of the assessment is titled "for the assessment of risk or potential towards behaviour that may impact on the safety of self, environment or others".

The resident's name is not on all of the pages. There is no signature bank available and it is unclear frequently who has signed the medical entries.

Although the consultant psychiatrist visits every week there are few written notes. The NCHD does the six-monthly psychiatric review. The name and title of those making the entries is required. The nursing notes were satisfactory. Again, in common with other services, the title of personnel was not supplied. Medication, prescription and administration records were satisfactory.

ENVIRONMENT

Each bungalow incorporates a reception area/hallway, six individual bedrooms, two bathrooms, both with showers and one with jacuzzi bath, two separate toilets, a living room, visitors' room, games room, kitchen, dining room, laundry room, staff office, staff toilet, shower and office. There is a smoking sitting room. Each bungalow is also supplied with its own minibus. To the rear of each bungalow is an extensive enclosed garden with a furnished patio area. Four of the bungalows have access to safe room facilities. This consists of a corridor between two bungalows which houses a safe room. The day services facility is in close proximity to the bungalows area. There is a secure entrance gate to the complex.

The maintenance is provided by St. Ita's Hospital and some work is contracted out. The buildings had been built to a very high standard of décor and comfort however there is a risk that without ongoing capital investment they may quickly fall into disrepair. Staff do all the laundry and a dryer cannot be used in any of the houses due to some plumbing difficulties which have yet to be resolved.

STAFF TRAINING

Staff are satisfied with the level of training they receive. Training in manual handling, cardio-pulmonary resuscitation and first aid is mandatory.

HILLTOP HOUSE, NAUL

Date of inspection: *23rd November 2005*

Number of beds: *7 integrated*

DESCRIPTION

Hilltop House provides a home, training and care for adults with intellectual disabilities. It is a large five-bedroom bungalow situated in Naul, County Dublin. It is approximately ten kilometres from Swords. It is surrounded by large mature gardens in a quiet rural setting. Hilltop House is owned by St. Joseph's Hospital. It provides a residence to seven residents, three male and four female. Three of the residents are in their seventies. It has 24-hour staffing but is viewed as a step down from Fern Lodge.

REFERRAL

Residents are usually referred from St. Joseph's Hospital or one of the high support group homes in St. Joseph's Hospital. They are usually referred by the resettlement committee. Residents admitted to Hilltop House are generally well known to the service and are assessed prior to their transfer there.

PROCESS OF ADMISSION

There are policies and procedures throughout St. Joseph's Service specific to community residences including the process for respite care and admission. There is no specific admission policy for Hilltop House. Generally residents here have a medium level of dependency and a dual diagnosis with a mild learning disability. Reasons for admission are generally for extended care. This facility does not offer respite care. Assessments are conducted prior to admission. If a person is referred to Hilltop House, a member of staff attends the resettlement meeting to discuss it. There is a detailed procedure for communication with family prior to discharge to the community residence. The consultant psychiatrist sees the resident prior to transfer and attends the individual resident plan meetings every six to 12 months. An initial treatment plan is documented and there is a key worker system in operation.

CARE PLAN

There is no formal multidisciplinary assessment although there is a detailed care planning system which involves the medical, nursing and care staff. The key worker is generally responsible for coordinating the care plan meetings and the consultant psychiatrist attends them. There is a psychiatric review every two months conducted by the consultant psychiatrist and a review conducted by the NCHD every three months. All residents here are registered with a local GP and their blood pressure and vital signs are checked in the residence every week by the staff.

As the residents admitted to this group home are generally perceived to be most likely to remain here there is no discharge planning. In the last year, one resident was re-admitted to the hospital.

NURSING PROCESS

The nursing care plan is based on the Orem human needs model and is deemed to be appropriate to the needs of the residents. A formalised risk assessment is being introduced in the hospital but has not yet been introduced here. There are regular reviews of care plan and a detailed policy in relation to this.

REHABILITATION TEAM

There was no rehabilitation team, though all residents here are under the care of a single clinical team. The consultant psychiatrist attends the individual resident plan meeting every six to 12 months. Residents are all registered with a GP and generally need to be accompanied to the GP by staff.

INVOLVEMENT IN REHABILITATION PROGRAMMES

A number of residents attend the Estuary day centre. The NCHD conducts the reviews at the Estuary centre. One resident attends Prosper in Fingal. Arrangements are made to accompany residents to their daily services although staff do not stay there with them.

CLINICAL RISK MANAGEMENT

There are plans to introduce formalised risk assessments and management plans throughout the service. Incident reports are completed following serious incidents and audited in the standard way.

Staff receive training in manual handling, HACCP, and cardio-pulmonary resuscitation, and also attend fire safety lectures.

UNIT MANAGEMENT

There are no temporary or long-term transfers from other units and the residence is not used for any other purposes. There are three nursing staff on day duty and one at night. At the time of inspection, there was an extra nurse on day duty and at night because of the specific needs of one of the residents. Staff are rostered to the unit. There is one care staff member on duty from 0800h to 2000h every day.

There is no waiting list and no residents were discharged to a lower level of support. Maintenance is available from St. Ita's Hospital. This is a major issue of contention in that there was no ongoing development programme. Staff and care staff share the responsibility for the household cleaning.

ETHOS

The stated philosophy of the facility is to ensure further integration of the residents into the community, involving them in social, leisure, occupational and domestic activities. The staff provide residents with a sense of home, belonging, personal identity, independence, equality, inclusion and diversity.

HOUSE RULES

There are no formalised house rules other than smoking being forbidden everywhere, apart from the front room. Residents are also required to notify staff if leaving the house. However none of the residents do go out unaccompanied. Visiting times are flexible. Residents can lock the bathroom door except when at a risk. Residents are allowed to leave unsupervised

but don't usually do so. Residents are not required to be out during the day. All the staff share the responsibility for preparing the meals which are prepared on site. Residents are infrequently involved in meal planning and shopping. Residents have free access to the kitchen to make drinks or snacks although they regularly request the staff to do so for them. Residents are not required to go to bed at set times and are not allowed to smoke in their bedrooms. In general they are facilitated as far as possible regarding who they share a room with. There is only one single room in the house and in general all the residents would prefer single accommodation. There are no facilities to accommodate a visitor. Residents are usually up for breakfast.

Residents' belongings are not listed. There are guidelines on handling monies collected from residents for rent and housekeeping. Residents are accompanied to the bank by staff and do not have independent access to their own money. Residents are in receipt of all benefits. They have not been asked to pay for new furniture and fittings for the residence since the change to the charges system. In fact the hospital even pays for the food. Residents buy their own clothes in the local shops with assistance. Staff generally do all the laundry. Residents bring their own laundry to the staff. Residents can access services in the community such as the shops and the pub. A hairdresser now comes into the house. Residents assist in cleaning and emptying the dishwasher. Local facilities are within walking distance. There is no access to public transport.

SERVICE USER INVOLVEMENT

There is little written information available to residents on treatment and therapies or rights, or the right to vote. There was a hospital-wide complaints policy. Residents generally attend part of the Individual Patient Plan (IPP) meeting. Their carers or families are often invited to the IPP and thus their opinions are obtained. There are no formalised community meetings with the residents, families or carers. Currently there is no access to advocacy.

RECORDS

The medical charts contained progress reports and were dated and signed. There was evidence of regular consultant psychiatrist review. In general there were weekly entries in the nursing charts unless the situation warranted more. A weekly report was sent to the CSO in Swords. Residents were not on a self-medication programme. The medication prescription and administration records were dated, legible and signed. Generic names were not used.

ENVIRONMENT

There is no regular ongoing maintenance programme in place. St. Ita's Hospital is responsible for providing maintenance. The unit needed refurbishment. Accommodation consisted of three double bedrooms and one single bedroom. There was a smoking sitting room to the right-hand side of the front door. There was a dining-cum-kitchen area with a non-smoking lounge directly off it – this was small but comfortably furnished with TV, DVDs and radios. There was a nurse's office which was being done up on the day of inspection. This room contained the medication press and case files. There was one utility room which inappropriately also housed the dishwasher and requests have been made to have this relocated. The kitchen needed upgrading, another sink is required for house washing. There was one main bathroom/shower room and one staff shower room and toilet. One of the residents had been moved into a double room to make a vacancy for a resident who required a single room and was quite distressed by the fact. The bathroom was not satisfactory. The shower, which was quite small, was directly inside the bathroom door and residents had to step up into it. The bathroom needed upgrading. In general the house was quite comfortable. However there was little opportunity for privacy. All the rooms were shared. Ideally there should be single rooms with en-suites.

ST JOSEPH'S INTELLECTUAL DISABILITY SERVICES

OVERALL RECOMMENDATIONS

1. Each resident should have an individualised care plan that contains a social, psychological, occupational, nursing and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the resident and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the resident has been involved in developing his or her care plan, and the resident must have a copy of the care plan. The care plan must be coordinated by the resident's key worker.
2. All written interventions and prescriptions must be dated, have a legible signature with the name and designation of the clinician clearly printed.
3. Residents must have physical and mental state examinations at least every six months and these should be recorded in the residents' clinical file.
4. A multidisciplinary rehabilitation team should be introduced within the service to assist with the rehabilitation of residents in the community. Each resident should be assessed for their future accommodation needs and appropriate resources provided.
5. There should be a dedicated admission unit for all new admissions.
6. All essential maintenance work should be carried out and a regular maintenance programme in place.
7. All patients should have access to an independent advocacy service.
8. Appropriate signage should be displayed advertising the use of CCTV.

ASHLEA UNIT

1. Staff should have access to training in de-escalation and breakaway techniques.

DÚN NA RÍ

1. The seclusion room must be cleaned as a matter of urgency.
2. Alternative forms of restraint must be used to eliminate the use of straitjackets.
3. There should be a policy on rapid tranquillisation.

DUNHAVEN

1. There should be a policy on restraint.

HILLVIEW UNIT

1. The appropriate seats should be purchased for all residents.

ST CLARE'S UNIT

1. Alternative forms of restraint must be used to eliminate the use of straitjackets.

ST BRENDAN'S AND AREA 6

RECOMMENDATIONS

AREA 6 COMMUNITY RESIDENCES

1. A multidisciplinary rehabilitation team should be introduced within the service.
2. Each resident should be assessed for their future accommodation needs and appropriate resources provided.
3. Each patient should have an individualised care plan that contains a social, psychological, occupational, nursing and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated by the patient's key worker.
4. The units should be self-staffing to ensure continuity of care.
5. There should be a structure in place for obtaining residents' and carers' views and feedback about the service.
6. All written interventions and prescriptions must be dated, have a legible signature with the name and designation of the clinician clearly printed.

ST BRENDAN'S COMMUNITY RESIDENCES

1. A multidisciplinary rehabilitation team should be introduced within the service.
2. Each resident should be assessed for their future accommodation needs and appropriate resources provided.
3. Each patient should have an individualised care plan that contains a social, psychological, occupational, nursing and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated by the patient's key worker.
4. The units should be self-staffing to ensure continuity of care.
5. There should be admission policies in place which should be adhered to at all times.
6. There should be an increase in staff to provide therapeutic activities for the patients.
7. Essential maintenance work should be carried out as a matter of urgency and a maintenance programme put in place.
8. All written interventions and prescriptions must be dated, have a legible signature with the name and designation of the clinician clearly printed.

ST BRENDAN'S HOSPITAL

ACUTE ADMISSION WARDS

1. The acute services in St. Brendan's Hospital must relocate to the new acute unit in Connolly Hospital as a matter of urgency.
2. The acute unit should not be providing a service for people with long-stay needs. The

service should be for people with acute mental health needs.

3. The numbers of psychologists, occupational therapists and social workers should be increased to ensure that each sector has a core multidisciplinary team.
4. Patients should not sleep in other units due to bed shortages.
5. The units should be self-staffing to ensure continuity of care.
6. Each patient should have an individualised care plan that contains a social, psychological, occupational, nursing and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated by the patient's key worker.
7. Essential maintenance work should be carried out as a matter of urgency and a maintenance programme put in place.
8. The policy on nursing people in their night attire should be reviewed.
9. Patients should not be admitted to an acute mental health unit for detoxification in the absence of mental illness.
10. All patients should have there own clothing and the use of pooled clothing must cease.
11. All patients should have a planned discharge from hospital.
12. The units should have access to a ward clerk.
13. All patients and staff should be kept informed of future plans for the hospital.

SPECIAL CARE WARDS

1. The numbers of psychologists, occupational therapists and social workers should be increased to ensure that each sector has a core multidisciplinary team.
2. Each patient should have an individualised care plan that contains a social, psychological, occupational, nursing and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated by the patient's key worker.
3. The policy of nursing patients in their night attire and the use of refractory clothing should be reviewed.
4. All patients should have there own clothing and the use of pooled clothing must cease.
5. Individual risk assessments leading to risk management plans must be completed on all patients to address the lack of privacy and dignity for the patients in particular to bathing and the provision of curtains around beds.
6. Patients should be involved in all aspects of their care and have the opportunity to give feedback to staff regarding the service being provided.
7. Appropriate signage should be displayed advertising the use of CCTV.
8. All patients should have access to an independent advocacy service.
9. There should be ward-based therapeutic activities, based on need, for patients unable to leave the units.
10. Any form of mechanical restraint should be reviewed and where deemed necessary prescribed by the consultant psychiatrist and documented in the patients file.

THE WILLOWS

1. There should be no further admissions or transfers to the unit.
2. Each patient should have an individualised care plan that contains a social, psychological, occupational, nursing and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated by the patient's key worker.
3. There should be ward-based therapeutic activities, based on need, for patients unable to leave the unit.
4. All patients should have there own clothing and the use of pooled clothing must cease.

CONNOLLY HOSPITAL

ACUTE UNIT

1. The policy on nursing people in their night attire should be reviewed.
2. Patients should not be admitted to an acute mental health unit for detoxification in the absence of mental illness.
3. Each patient should have an individualised care plan that contains a social, psychological, occupational, nursing and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated by the patient's key worker.
4. All patients should have a planned discharge from hospital.
5. The numbers of psychologists, occupational therapists and social workers should be increased to ensure that each sector has a core multidisciplinary team.
6. All policies should be reviewed and updated where appropriate.
7. Essential maintenance work should be carried out as a matter of urgency and a maintenance programme put in place.

UNIT 3

1. Each patient should have an individualised care plan that contains a social, psychological, occupational, nursing and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated by the patient's key worker.
2. All policies should be reviewed and updated where appropriate.
3. There should be ward-based therapeutic activities, based on need, for patients unable to leave the units.
4. Essential maintenance work should be carried out as a matter of urgency and a maintenance programme put in place.

North Dublin

ST ITA'S HOSPITAL

ADMISSION UNIT

1. The plans for a new acute unit on the Beaumont Hospital site need to be advanced and a new unit commissioned.
2. All decisions to admit a patient should be discussed with a consultant psychiatrist.
3. Patients should not be admitted to an acute mental health unit for detoxification in the absence of mental illness.
4. Each patient should have an individualised care plan that contains a social, psychological, occupational, nursing and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated by the patient's key worker.
5. The numbers of psychologists, occupational therapists and social workers should be increased to ensure that each sector has a core multidisciplinary team.
6. Consideration should be given to reviewing the practice of using refractory clothing on patients in seclusion.
7. Appropriate signage should be displayed advertising the use of CCTV.
8. Patients should not sleep in other units due to bed shortages.
9. All written interventions and prescriptions must be dated, have a legible signature with the name and designation of the clinician clearly printed.

WILLOWBROOK UNIT

1. Each patient should have an individualised care plan that contains a social, psychological, occupational, nursing and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated by the patient's key worker.
2. There should be ward-based therapeutic activities, based on need, that facilitate rehabilitation.
3. Policies should be in place to govern the practice of locking the external door, patients' leave from the unit, and drug testing for illicit drugs.
4. Appropriate signage should be displayed advertising the use of CCTV.

WARDS 8 AND 9

1. Each patient should have an individualised care plan that contains a social, psychological, occupational, nursing and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated by the patient's key worker.
2. The units should be self-staffing to ensure continuity of care.

UNIT 1 MALE AND FEMALE (PSYCHIATRY OF LATER LIFE)

1. There should be a written policy governing admissions and respite care.
2. Patients should not sleep in other units due to bed shortages.
3. Any form of mechanical restraint should be reviewed and where deemed necessary prescribed by the consultant psychiatrist and documented in the patient's file.
4. Essential maintenance work should be carried out as a matter of urgency and a maintenance programme put in place.
5. The units should be self-staffing to ensure continuity of care.
6. All written interventions and prescriptions must be dated, have a legible signature with the name and designation of the clinician clearly printed.

AREA 8

COMMUNITY RESIDENCES OVERALL

1. A full multidisciplinary rehabilitation team should be introduced within the service.
2. Each resident should be assessed for their future accommodation needs and appropriate resources provided.
3. All written interventions and prescriptions must be dated, have a legible signature with the name and designation of the clinician clearly printed.
4. Essential maintenance work should be carried out as a matter of urgency and a maintenance programme put in place.
5. There should be a structure in place for obtaining residents' and carers' views and feedback about the service.
6. All residents should have access to an independent advocacy service.
7. There should be a clinical risk management policy in place.

AREA 7

ST VINCENT'S HOSPITAL, FAIRVIEW

1. A full multidisciplinary rehabilitation team should be introduced within the service.
2. Each resident should be assessed for their future accommodation needs and appropriate resources provided.
3. Each patient should have an individualised care plan that contains a social, psychological, occupational, nursing and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated by the patient's key worker.
4. There should be ward-based therapeutic activities, based on need, that facilitate rehabilitation.
5. Patients should not sleep in other units due to bed shortages.
6. All decisions to admit a patient should be discussed with a consultant psychiatrist.
7. Essential maintenance work should be carried out as a matter of urgency and a maintenance programme put in place.
8. Consideration should be made to reviewing the policy on the use of refractory clothing in St. Louise's ward.
9. All patients should have access to an independent advocacy service.
10. Patients must have regular physical and mental state examinations and these should be recorded in the patients' clinical file.

AREA 7 COMMUNITY RESIDENCES

1. A full multidisciplinary rehabilitation team should be introduced within the service.
2. Each resident should be assessed for their future accommodation needs and appropriate resources provided.
3. Each patient should have an individualised care plan that contains a social, psychological, occupational, nursing and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated by the patient's key worker.
4. Essential maintenance work should be carried out as a matter of urgency and a maintenance programme put in place.

MATER HOSPITAL

ST ALOYSIUS' WARD

1. An interview room should be constructed within A&E that ensures the patients' right to confidentiality is maintained.
2. Patients with mental health problems seen in A&E who require admission must be transferred without delay to the appropriate mental health service.
3. There should be a high observation area.
4. Each patient should have an individualised care plan that contains a social, psychological, occupational, nursing and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated by the patient's key worker.
5. All patients should have a needs-based therapeutic programme that facilitates their rehabilitation.
6. The facilities for the provision of ECT must be improved to include a separate waiting area, treatment area and recovery area.

North Dublin