Report of the Inspector of Mental Hospitals

for the year ending 31st December, 2001

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Contents

Introduction

To the Minister for Health and Children

In pursuance of the provisions of Section 247 and 248 of the Mental Treatment Act 1945, I am submitting to you my report for the year 2001 on psychiatric hospitals and services and the care of patients therein. This is my fourteenth report since my appointment in November, 1987.

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

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

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

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

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

Dermot Walsh
Inspector of Mental Hospitals

Glossary

A & E	Accident and Emergency.
ACNO	Assistant Chief Nursing Officer.
Catchment Area	Refers to the area traditionally served by a district mental hospital. In many cases, catchment areas correspond with county boundaries. In Dublin and Cork, the catchment boundaries correspond in most cases with those of the community care areas of the health boards.
Clinical Director	The clinical director is the consultant psychiatrist responsible for a psychiatric hospital and services in the catchment area served by the hospital. Clinical directors may also be known as resident medical superintendents, see RMS below.
CNO	Chief Nursing Officer.
CPN	Community Psychiatric Nurse.
CPR	Cardio Pulmonary Resuscitation.
Day Centre	A day centre provides social care for patients and it may also offer treatment. Rehabilitation and activation services may be provided and could include occupational therapy, social skills training and light industrial therapy.
Day Hospital	A day hospital provides comprehensive treatment equivalent to that available in a hospital in-patient setting for acutely ill patients. Clinics can also be held and a range of investigative procedures performed. The day hospital acts as the focus of psychiatric care in an area and is primarily for active treatment of patients with psychiatric disorders.
De-designation	The term used to indicate that a part of a psychiatric hospital has been formally separated from the hospital and its patients are no longer considered to be psychiatric patients. Accommodation for older people and patients with intellectual disabilities in a number of hospitals has been de-designated.
DNO	Deputy Nursing Officer.
ECT	Electro-convulsive therapy.
ESF	European Social Fund.
FBAO	Foreign body in airway obstruction.

GP	General Practitioner.
Integration	May refer to the integration of male and female patients in the same ward or the integration of male and female nursing staff or both.
Intensive Care Unit	A specialised unit within the Mental Health Service providing observation and treatment of patients for whom management on an acute ward is not possible.
Long-stay	A patient who has been continuously hospitalised for over one year.
Mental Health Centre	The mental health centre offers both day hospital and day care facilities but has a wider remit than a combined day facility. It acts as the centre of the psychiatric service in a sector and the sector team has its headquarters there. It also provides a number of twenty-four hour care beds for assessment and crisis prevention purposes and the development of a comprehensive mental health centre is a particularly suitable method of moving towards a more community-oriented psychiatric service.
New long-stay	A patient who has become continuously hospitalised for over one year in the past year.
NCHD	Non-Consultant Hospital Doctor. A doctor in one of these posts is usually in training for a consultant post or as a general practitioner.
NO	Nursing Officer.
PRN Prescription	Pro re nata prescriptions. Prescriptions given, as necessary.
Planning for the Future	Title of the Report of a Study Group on the Development of Psychiatric Services. December 1984 (PL 3001)
PUM	Acronym for person of unsound mind. Such persons are a category of patient who may be admitted to and detained in a district mental hospital under section 162 of the Mental Treatment Act, 1945.
Restraint	Restraint of a patient in a mental institution is the application of clothing or other material means whereby the movements of the body or any part of the limbs of a patient are restrained or impeded.
RMHN	Registered Mental Handicap Nurse.
RMS	Resident Medical Superintendent. The RMS is the consultant psychiatrist responsible for a district mental hospital with defined functions under the Mental Treatment Act, 1945.
Seclusion	Seclusion of a patient means the placing of a patient (except during the hours fixed generally for the patients in the institution to retire for sleep) in any room alone and with the door of exit locked or fastened or held in such a way as to prevent egress of the patient.

Sector/ Sectorisation	Planning for the Future (see above) described sectorisation as the process of providing a comprehensive service for a population of known size normally resident within a clearly defined district. The recommended population for a sector is 25,000-30,000. In many parts of the country, psychiatric services are organised in sectors on the model recommended in the Report.
Secure Unit (CMH)	Units providing care and treatment under conditions of greater security than those ordinarily provided by the Mental Health Service. Patients require special treatment and care because of dangerous or criminal propensities and the likelihood of seriously endangering self or others. These units must be closely allied to the management, ethos and practice of the developing forensic psychiatric service.
Temporary Patient	A patient who is suffering from mental illness believed to require for his/her recovery not more than six months suitable treatment and is unfit on account of his/her mental state for treatment as a voluntary patient or who is an addict and is believed to require, for his/her recovery, at least six months preventive and curative treatment.
WTE	Whole-time Equivalent.

CHAPTER ONE

The Psychiatric Services in 2001 — An Overview

THE PROCESS OF INSPECTION

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

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

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

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

The designation, Inspector of Mental Hospitals, derives from the Mental Treatment Act 1945, at a time when the entire mental health service provision consisted almost exclusively of mental hospitals. The situation has greatly changed and, increasingly, more mental health care is delivered in non-hospital settings than is provided in hospitals. Accordingly, the role of Inspector of Mental Hospitals has had to acknowledge this reality. Indeed, the forthcoming legislation, the Mental Health Act 2001, acknowledges this changed function by the creation of an Inspectorate of Mental Health Services, rather than of mental hospitals. Over many years, the Inspectorate has included community-based services within its brief, in addition to services of the traditional, institutional type. There are other areas of mental health care which, although not legislatively or logistically coming within the Inspectorial remit, are nevertheless of considerable concern. These include mental health promotion on a community basis, access to primary care for persons with mental

health problems, and the organisation and quality of primary health care so that it can effectively recognise, diagnose, treat and refer persons with such problems. The Inspectorate is, likewise, concerned about support for carers of persons suffering from major psychiatric disorder, on whom considerable burdens devolve, no matter how adequate the help available from the statutory services may be. The Inspectorate is also deeply concerned about safety issues, and advocates the enhancement of safety provisions and measures available to mental health service staff through the training programmes put in place for them, both on induction and subsequently, and through the existence of risk assessment procedures.

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

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

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

- Case record structure, quality of entries and documentation, medical, nursing and other;
- Prescribing practices and documentation;
- Consumer involvement in service planning;
- Care planning and patients' involvement in planning individual care programmes;
- Risk assessment and management;
- Patient privacy and dignity;
- Complaints procedures, complaints officers and complaint management and recording;
- Seclusion, its practice and documentation;
- Protocols on the locking of in-patient accommodation;
- Accidents and incidents, their recording and prevention;
- Patient money management systems;
- Policy on search of patients and their property;

- Patients absent without leave;
- Follow-up and care programme approach for patients on discharge from in-patient care;
- Policies and procedures generally and clinical and administrative guidelines.

GENERAL STATE OF MENTAL HEALTH SERVICES IN 2001

According to the figures supplied to the Department of Health and Children by service providers, there were 4,256 patients resident (including those on parole) in psychiatric hospitals (public and private) and acute psychiatric units on 31 December 2001. During that year there had been 26,037 admissions to these in-patient facilities, 2,597 of which were non-voluntary. Details of the socio-demographic and medical characteristics of resident and admitted patients in each individual service can be found in the body of this report, and also in *Irish Psychiatric Hospitals and Units Census 2001* and *Activities of Irish Psychiatric Services 2000*, published by the Health Research Board.

Coincidental with the decline in numbers of patients, there have been ward closures in several psychiatric hospitals during the year. The psychiatric unit at Ennis General Hospital opened in December 2001. Further general hospital psychiatric units at St Luke's Hospital, Kilkenny, Mayo County Hospital, Castlebar, and at Portlaoise general hospitals, were completed or nearing completion, and were expected to be fully functional during 2002. Our Lady's Psychiatric Hospital in Ennis was planning closure in early 2002 and the small number of patients remaining in Our Lady's Psychiatric Hospital in Cork was due to transfer to the new St Anne's Unit in Shanakiel in Cork city, with the final closure of Our Lady's. The transfer of acute psychiatric care from traditional psychiatric hospitals to general hospital units was in line with current national policy for mental health service delivery and increased the number of persons treated in these modern and up-to-date units. The proportion of admissions being treated in general hospital units, which stood at over 40 per cent at the end of the year 2000, was expected to have increased considerably by the end of 2002. In James Connolly Memorial Hospital, Blanchardstown, and St Vincent's Hospital, Elm Park, construction of new acute psychiatric units was well under way to replace the highly unsatisfactory admission provision currently existing in St Brendan's Psychiatric Hospital, James Connolly Memorial Hospital and Vergemount Hospital, Clonskeagh. Some other services were in an advanced stage of planning their new psychiatric units, such as the one for Sligo General Hospital to serve the Sligo/Leitrim mental health service.

Provision of community-based residential accommodation alternatives to run-down, old-fashioned and unsatisfactory psychiatric hospital accommodation proceeds somewhat unevenly throughout the country. Services such as those in Clare and Sligo/Leitrim, for example, have completely, or almost completely, substituted domestic-style community residential accommodation for the former, unsatisfactory mental hospital provision. A small number of long-stay patients in St Finian's Hospital, Killarney, St Mary's Hospital, Castlebar, and St Luke's Hospital, Clonmel, remain awaiting transfer to more satisfactory

residential accommodation than is currently provided for them, preferably in a community location.

There have been a number of significant initiatives during 2001 and, before going on to consider more specific matters, these are now set out.

MENTAL HEALTH ACT 2001

The Mental Health Act 2001 passed all stages of consideration by the Oireachtas during the year and received Presidential signature on 5 July 2001. It will be brought into effect, on a phased basis, on a date or dates to be prescribed by the Minister for Health and Children. The Act provides, inter alia, for the establishment of a Mental Health Commission and for the automatic independent review of every episode of non-voluntary detention of persons in a psychiatric centre, through the setting up of Mental Health Tribunals. The Commission will be established during 2002. Letters requesting the nomination of persons to be considered for membership by the Minister were sent to appropriate representative and other bodies at the end of 2001.

NATIONAL HEALTH STRATEGY

The Health Strategy document, *Quality and Fairness — A Health System for You*, outlining general health policy for the years ahead, was published during the year and set out four general National Goals: better health for everyone; fair access; responsive and appropriate care delivery; and high performance. Each of the goals has a number of objectives; for example, through objective four of Goal number one, a new action programme for mental health will be developed. Two of the key actions to improve mental health services and promote awareness, as identified in the objective, are the setting up of the Mental Health Commission, and the putting in place of a national policy framework for the further modernisation of mental health services. In addition, services aimed at specific groups will be further developed, including those serving older people and those who would benefit from community-based alcohol treatment programmes. Also, programmes to promote positive attitudes to mental health will be introduced, patient advocacy services encouraged and resourced, and suicide prevention programmes intensified. Under National Goal 2, Fair Access, eligibility for health and personal social services is clearly defined and among the core services identified, as free of charge for all, are specialist mental health services. Under National Goal 3, Responsiveness and Appropriate Care Delivery, there is a commitment to delivering appropriate care in appropriate settings and, under this objective, among the existing problems to be remedied in this regard are people with intellectual disability being cared for in psychiatric hospitals and mentally ill patients being treated in large psychiatric hospitals unsuited to modern high-quality care. In addition, under this National Goal, there is a commitment to providing a programme of investment to increase community care services, including day hospitals, residential hostels, community nursing, and training and work programmes, and to complete the national programme of provision of acute psychiatric units. In addition, the Strategy is committed to expanding health information systems, already developed in the mental health field, and health research to provide the background for an evidence-based

approach to all of the National Goals, in part through the appointment of research and development officers in health boards.

The Inspectorate welcomes the basic principles of the Health Strategy, including those set out in the Strategy for Primary Care with the vision of increased involvement of primary care in psychiatric illness and of identifying and treating psychiatric factors in general health care. The further commitment aspired to in the Health Strategy relating to improving and accelerating the provision of acute psychiatric units and other physical resources in mental health services is also in line with the aspirations and recommendations of the Inspectorate over many years. The issue of equality of service provision as between the private and public sector is one which has preoccupied the Inspectorate for some time and we are glad to report that some of the more glaring instances of disparity in the quality of accommodation in the two sectors have been gradually disappearing over the years. The Inspectorate has in recent years worked closely with the Health Research Board in advocating and promoting the advantages of health information systems maintained by them, such as the National Psychiatric In-patient Reporting System, and initiatives on health services research in the mental health care delivery field.

MEDICAL MANPOWER FORUM

The Inspectorate has noted the reports of the National Steering Group on the Working Hours of Non-consultant Hospital Doctors and the report of the Forum on Medical Manpower, and the commitment to establishing during 2002 a Medical Manpower Committee. It applauds one of the prime recommendations of the Forum, the commitment to providing, as far as possible, first-line consultant services so that mental health services, like other medical and surgical services, come to be consultant-delivered as well as consultant-led.

WORKING GROUP REPORT ON CHILD AND ADOLESCENT PSYCHIATRY

A working group established during the year 2000 to make recommendations on the development of child and adolescent psychiatry presented its first report to the Minister in March 2001. The Report contained proposals for the development of services, for the management and treatment of attention-deficit hyperactivity disorders/hyperkinetic disorders (ADHD / HKD), and for the development of child (aged 6 to 12 years) and adolescent (aged 12 to 16 years) psychiatric in-patient units. The Report recommended the enhancement and expansion of the overall child and adolescent psychiatric services throughout the country, and closer liaison and interaction with the education system and with other areas of the community health services. The Report recommended that a total of seven in-patient psychiatric units catering for children aged between six and sixteen years should be established throughout the country, with a focus on assessment and treatment of psychiatric, emotional or family disorders, including major adjustment disorders, anxiety disorders, mood disorders, eating disorders and schizophrenia, using a variety of treatment approaches. The cost associated with implementing the working group's recommendations was estimated at approximately €114 million. Each health board has in place at present a minimum of two consultant-led multi-disciplinary teams in child and adolescent psychiatry. Five new units were to be developed and funded under the National Development Plan 2000-2006; three of the units were currently at the planning stage.

WORKING GROUP ON PSYCHIATRIC SERVICES FOR ADOLESCENTS AGED SIXTEEN TO EIGHTEEN YEARS

New legislation raising the age of childhood from sixteen to eighteen years has consequences for psychiatric services. A working group, with representation from the Inspectorate, was set up during 2001 to explore the implications of this change in the provision of services for young people, with particular reference to the co-operation necessary between the child and adolescent services on the one hand, and those for adults on the other. This group will report during 2002.

WORKING GROUP ON 'ESCORTS'

We have referred in earlier reports to the problems caused by the instruction issued to its members by the Psychiatric Nurses' Association directing them not to participate in the escorting of patients to be admitted involuntarily to psychiatric hospitals nor to escort back to hospital involuntary patients leaving without permission. A working group representative of appropriate parties was set up during 2001 under the aegis of the Health Services Employers' Authority to confront the difficulties arising and to strive for a resolution.

THE GARDAÍ AND MENTAL HEALTH

Under this heading in the 1998 Report, the Inspectorate expressed concern about the lack of involvement of the Gardaí in community mental health, identifying them as a prime community agent who, in the course of their duties, inevitably came across mental health problems. The Inspectorate expressed the view that training for Gardaí in the elements of mental health care provision was necessary and further recommended that, in each divisional area, certain officers should be designated mental health specialists to deal with and advise on issues likely to confront them and their colleagues in their ordinary duties and to ensure a fruitful co-operation and liaison with mental health professionals and primary care health agencies. During 2001 the Department, with Inspectorate representation, visited the Garda training headquarters in Templemore and had fruitful discussions with senior Garda representatives in relation to the establishment of a suitable training module on mental health for student Gardaí. This was a most welcome development and the Insepctorate looks forward to further co-operation with the Gardaí in this area.

MEDICAL STAFFING

At the end of 2001, there were 261 established permanent consultant posts in psychiatry in the public mental health service and, of these, fifteen had been approved during the year 2001, bringing the total of new consultant psychiatrist posts approved in the five-year period, 1996 to 2001, to fifty-seven. Many of the new posts created were in the subspecialties, particularly those of child psychiatry and the psychiatry of later life. At the year's end, there were forty-five consultant posts in child psychiatry, twenty-nine in the psychiatry of learning disability, twenty in the psychiatry of later life, and five in forensic psychiatry. Liaison psychiatry accounted for six posts, rehabilitation psychiatry for five, and the psychiatry of substance abuse for a further four. Eighteen psychiatrists were

reported as being in practice exclusively in the private sector. There were 373 non-consultant hospital doctor posts, of which 130 were filled by non-nationals. Recruitment of non-consultant hospital doctors in sufficient numbers to fill established posts had been a difficulty for a small number of services during the year. Most of the non-consultant hospital doctors were participating in basic training schemes ultimately leading to specialist qualification. In addition, there were twenty-six higher training posts at senior registrar level. With approximately four such posts becoming available annually, the capacity of the higher training scheme to cater for those desirous of entering higher training was quite inadequate. As a consequence, the majority of Irish psychiatric trainees, having completed basic training, were obliged to go abroad, mainly to the United Kingdom, to complete their higher training. It is the opinion of the Inspectorate that the postgraduate training scheme in psychiatry needs serious scrutiny with a view to bringing about a more satisfactory balance between higher training posts and vacancies arising in consultant posts.

NURSING

November 2001 was a significant month in the history of nurse education and training in Ireland. For the first time, it was agreed that the registration programme in psychiatric and intellectual disability nursing would be at degree level. Successful completion of the new four-year degree programme will lead to registration with An Bord Altranais and the award of Bachelor of Science (BSc) degree in nursing from the Higher Education Authority. This new degree programme will replace the three-year diploma programme and will commence in October 2002, with 343 places in psychiatric nursing and 240 places in intellectual disability nursing. A continuous twelve-month rostered clinical placement, inclusive of four weeks annual leave, will take place during the fourth year of the programme, and during this period the student will be a paid employee of the health service.

While nurse recruitment appears to outstrip resignations and retirements on a national basis, services within the Eastern Region continue to experience staffing and manpower difficulties, with an over-reliance on overtime or agency nursing. This manpower difficulty in the Eastern Region, and to a lesser extent in the Southern Health Board area, has led to a massive recruitment drive overseas, in the European Union, Africa, the Middle East and Asia. The impact of the influx of large numbers of non-national nursing personnel to local health services is unknown at this early stage. However, their arrival in the system should go some way to alleviate the acute staffing difficulties experienced by some services, particularly in the Dublin area.

During the year, the government approved a new sponsorship scheme for experienced care assistants working in the public health service who wished to train as nurses. This scheme will be introduced in 2002, with up to forty sponsorships available annually. Successful applicants will continue to be paid their normal salaries throughout the four years of the new degree programme in return for a commitment to work as nurses in their health service agency for a period of five years following completion of the programme. This sponsorship scheme is the latest in a series of welcome initiatives developed over the past couple of years to recruit and retain nurses in our public health care system.

A new independent body established in 1999, the National Council for Professional Development of Nursing and Midwifery, began the process of providing guidance and support on the development and appointment of clinical nurse specialists and advanced nurse practitioners. During the year, this body published a number of documents which outlined the criteria and processes to be applied. A total of 156 community psychiatric nurses were approved in posts as community mental health nurses. Postgraduate courses should be established to train and equip psychiatric nurses to meet the criteria for clinical nurse specialists and advanced nurse practitioner posts. All applicants will need to be educated to higher diploma level or above in the case of clinical nurse specialists, and to master degree level or higher in the case of advanced nurse practitioners. The availability of these courses nationally will ensure equal access for all nurses wishing to follow a clinical career path.

STAFFING

The Inspectorate has, for a long time past, been concerned about the rigidity and unimaginative nature of the staffing in mental health services. Representative organisations, particularly in nursing, have dictated and dominated this aspect of service provision and have impeded flexibility in working and, in particular, in allowing services to arrive at a skill mix most appropriate to the requirement and need in particular situations. Much of this has prevented services from initiating improvements and more effective and efficient methods of care. Such inflexibility has hindered staff development and progress. Staff management systems, themselves often suffering from the same shortcomings, are not sufficiently lively and energetic in devising and seeking out other approaches to encourage, in particular, younger and more imaginative members of staff in pursuing gratifying approaches and inputs to their work.

SOME SERVICE PROVISION ISSUES

Community Residential Accommodation

Time and again, the Inspectorate has been struck by the number of current psychiatric inpatients who are homeless and are accommodated in acute or long-stay hospital wards despite being suitable for community residential placement. There is hardly a service in Ireland where this is not a current issue. The reasons why such people have not moved on to community, domestic-scale residences are multiple; in some cases suitable properties are not available, in others, particularly in Dublin and other metropolitan areas, premises have become prohibitively expensive. Elsewhere, such as at Edgeworthstown in Co Longford, where suitable premises had become available, lack of agreement with representative organisations ensured patients' continued to reside in unsatisfactory hospital accommodation. Securing local authority housing for persons suffering from the disablement of psychiatric illness remained a difficulty in some locations. However, the efforts of voluntary housing agencies, such as local mental health associations, have increased the provision of community residential accommodation, with funding, in major part, from the Department of the Environment and Local Government. This initiative, which has taken place in several areas in recent years, is to be applauded and has contributed significantly to the improvement of mental health care in this country.

Community Mental Health Centres, Sector Headquarters and Day Hospitals

The Inspectorate sees the siting of community-based centres of psychiatric activity in each sector as an example of the implementation of the four main Health Strategy principles of better health for everyone, fair access, responsive and appropriate care delivery and high performance. The Inspectorate would argue that without such a functioning presence in every sector, away from the in-patient base, there is a serious failure of mental health care delivery in keeping with the Health Strategy goals and objectives. In the majority of instances, such premises do not exist or are inadequate in structure and size for the identified purpose of their activities. As well as this, there is, in many instances, a reluctance on the part of mental health professionals to centre their activity and their working day in a community setting. This can be achieved without, of course, neglecting their in-patient commitments. Eventually, the reciprocity between the two sites of service provision will lead to a balance but as community activity increases, so the need for in-patient-based activity should decrease. Additionally, the shifting of patients from in-patient hospital bases to community settings will also reduce the in-patient burden on clinicians.

Similar difficulties arise in relation to the concept of day hospital assessment and treatment. Our experience countrywide is that health professionals are confused in their conceptualisation of what a day hospital should be about, what patients it should treat and what treatments should be available. In many instances, so-called day hospitals do not deal with a broad range of psychiatric disorder, particularly the more serious disorders, and do not provide a broad range of treatments; ideally, a day hospital should provide every treatment that is available in an in-patient setting. Many premises are too small or do not have sufficiently large internal spaces to deal with more serious illness. Because of these difficulties, the Department has commissioned a study of day hospitals and their functions on a sample basis throughout the country from the Health Research Board as part of the Board's on-going programme of health services research in the mental health field. The Inspectorate understands that the results of this study should be published before the end of 2002.

Older Persons in Psychiatric Hospitals

Currently, close to forty per cent of persons resident in psychiatric units and hospitals are over sixty-five years and in some instances, particularly among the long-stay patients, this figure exceeds fifty per cent. Many, but not all, of these older persons now show little sign of behavioural disturbance related to psychiatric disorder and, among the more elderly of them in particular, their needs and disabilities relate to their age rather than to any psychiatric disorder. Their continued residence in long-stay psychiatric facilities is neither appropriate nor best suited to their needs. Their remaining on the psychiatric register is neither helpful clinically nor appropriate from a civil rights point of view. The Inspectorate has been urging the transfer of their care either to community residences where that is possible or to suitable in-patient continuing care facilities for older persons or, when they remain in psychiatric structures, their de-designation from the psychiatric register and the provision of their medical care by general practitioners.

The Physical Health of Resident Patients

Research has shown, time and again, that psychiatric patients enjoy poorer health and have higher mortality than the general population. There are several factors contributing to this. The onus on those responsible for the physical health of patients resident, particularly long-term, in psychiatric hospitals or community residences, is all the more pressing because of this consideration. It is incumbent on service deliverers to have frequent assessment of the physical health of in-patients. It is disquieting to the Inspectorate to have to record that physical health examination of in-patients, as documented in case note material, is often infrequent, desultory and superficial in nature. It is self-evident that some psychiatric patients may not complain of subjective distress. Additionally, patients have the right and should be encouraged to partake in health screening programmes, such as breast screening. Health education programmes should be directed equally at in-patients and community residents, as at the general population. All patients residing in community residences are registered with GPs under the General Medical Services Scheme and carers should ensure that patients visit their GPs frequently for routine physical appraisal.

Smoking and Health

The Inspectorate issued a circular to all mental health service providers during 2001 requesting a review of local smoking and health policies, with a view to promoting the health of patients and staff and providing a safe and unpolluted environment for all. This circular recommended the provision of specifically designated smoking areas, which should be clearly identified, at each location, and recommended that every effort be made in all mental health services to comply with the Tobacco (Health Promotion and Protection) Regulations 1995. The Inspectorate recommended that the practice in some services of distributing tobacco products from stores or ward stock to patients and the payment of cigarettes in lieu of cash should be discontinued. The circular also recommended a review of the payment of comfort monies to patients and the provision of the necessary assistance, support and encouragement for patients to cut down on the consumption of nicotine

Sudden Deaths

Under Section 272 of the Mental Treatment Act, sudden deaths are reported to the Inspectorate. There were nine cases of suicide among psychiatric patients in 2001. Four of these deaths occurred in in-patient settings, three while the patients were absent without leave from hospital, and two while the patients were on authorised leave. Five of the deaths were by drowning, three by hanging and one by jumping from a building. The Inspectorate has requested all services to review, in depth, all deaths by suicide of patients in their care with a view to scrutinising existing clinical management and risk assessment of patients for the possibility or likelihood of self-injury, including the periodic scrutiny of procedures relating to the problem of absence without leave and the granting of authorised parole.

Sudden deaths, other than those by suicide, occur in psychiatric in-patients. Such deaths are generally either due to asphyxia from the inhalation of food or other material, mainly

in older patients, or are drug related. During the year 2001 there were nine sudden deaths, not directly attributable to natural causes, among psychiatric residents. Consideration of post-mortem and, where applicable, inquest reports, indicated that three of these deaths were due to aspiration pneumonia following, in two cases, the ingestion of food and, in the third case, an article of clothing. Three were possibly the consequence of drug interaction, one was due to a brain haemorrhage following a fall, one resulted from injuries sustained while the patient was being restrained and is the subject of an ongoing investigation. In the final case, post-mortem examination was unable to establish the cause of death.

In relation to the first circumstance, the Inspectorate has advocated, and inquires about at each inspection, the training of staff in the appropriate procedures in cases of foreign body airway obstruction and the care necessary in feeding many older, feeble patients with poor swallowing capacity.

On the second circumstance, that of sudden deaths that may be drug related, the Inspectorate has urged caution in relation to drug prescribing, the frequent review of the necessity for prescribed medication and of any side effects deriving from it, and avoidance of poly-pharmacy. In this context, it is relevant to point out that the Irish Medicines Board (IMB) issued a notice during 2001 advising that the drug Thioridazine (Melleril) should be prescribed only when other treatments have proven unsuitable. The IMB also recommends that patients be thoroughly assessed physically, including having electro-cardiograms and blood tests performed before receiving the drug and periodically during treatment. It would be the further advice of the Inspectorate that, before any patient with physical health problems, or suspected problems, is started on anti-psychotic or anti-depressant or other relevant medication, he or she be the subject of a thorough physical examination.

The Intellectually Disabled in Psychiatric Hospitals

We have over many years regarded the practice of continued care of intellectually disabled patients in long-stay psychiatric facilities as inappropriate and have recommended their transfer to appropriate services, residential and otherwise, to enable them to get the skilled and specialised care not generally available in psychiatric hospitals. Fortunately, some progress has been made in alleviating this problem in recent years and in 2001 a substantial number of such persons were transferred from St Joseph's Hospital, Limerick, St Canice's Hospital, Kilkenny, St Mary's Hospital, Castlebar, and St Finan's Hospital, Killarney, to much better and more appropriate accommodation in specialised centres for the intellectually disabled at Lisnagry in Limerick, Kilkenny City, Swinford, Co Mayo and Ballydibeen, Killarney, respectively. However, not inconsiderable numbers of such persons remain in unsuitable accommodation in St Senan's Hospital, Enniscorthy, St Luke's Hospital, Clonmel, and St Brigid's Hospital, Ardee. The special situation obtaining in St Ita's Hospital, Portrane, where a partially specialised service for the 300 such persons in the St Joseph's service in St Ita's continues. This service is still administered as part of the overall psychiatric service, but it is the Inspectorate's position that a separate and reinforced administration with enhanced clinical specialisation is necessary to optimise the service available to this group of persons.

The Psychiatry of Later Life

Considerable progress has been made in the last few years in providing specialised services for psychiatric illness in older persons, with the appointment of consultant psychiatrists for this sub-specialty. Currently, there are fifteen such consultants in place throughout the country, five further established posts not yet filled, and further posts are being created and will shortly be advertised. In most instances, a small number of acute assessment beds are being provided in separate sub-units in new general hospital units for the assessment and acute treatment of such patients, although in one instance a six-bed sub-unit for the elderly in the psychiatric unit in Tallaght Hospital, although provided in August 1999, had not opened at the end of 2001 because of nurse shortages. In many cases, a full multi-disciplinary team has not been available to the later-life services, thus restricting the range of their functions. Day hospitals providing such services are required, preferably adjoining general in-patient hospital facilities for the elderly; for the most part, these have not yet been put in place.

Forensic Psychiatry

Given the considerable increase in the prison population which has occurred in recent years, and because of the perception of a high prevalence of psychiatric disorder among prisoners, the Department of Health and Children has taken steps to expand considerably forensic psychiatric services. There are now five consultant forensic psychiatrists in the Dublin region and plans are afoot to provide special interest consultant forensic inputs to Cork and Limerick prisons. Together with the increase in consultant personnel, there is also an expansion and re-conceptualisation of the areas of function of the forensic psychiatric services.

Prison Health Care Services

The Group established by the Minister for Justice, Equality and Law Reform in 1999 to review the Structure and Organisation of Prison Healthcare Services reported in May 2001. The Review Group gave the historical background of the prison mental health care services and a summary of current mental health care provision. The Group suggested a formal partnership between the Department of Justice, Equality and Law Reform, the Irish Prison Service, the Department of Health and Children and the health boards, as the Group endorsed the view that for health care purposes prisons are, in effect, an extension of the community. The Group considered that the establishment of this partnership arrangement, both centrally and locally, was essential in order to ensure the equivalence of health care between the prisons and the general community. The Group proposed a working party be established between the Department of Justice, Equality and Law Reform, the Irish Prison Service and the Department of Health and Children to examine the specifics of such a partnership. Legislation to facilitate the diversion of mentally ill persons from the criminal justice system, including the courts and the prisons, to alternative treatment, supervision and care was advocated by the Group.

Central Mental Hospital (CMH)

Originally opened in 1850, the eighty-four-bed Central Mental Hospital is the only forensic psychiatric hospital in Ireland. Patients may be admitted through the criminal justice system or under the provisions of the Mental Treatment Act 1945.

While the Mental Health Act 2001, when fully implemented, will provide for automatic, independent review of every case of non-voluntary detention in psychiatric centres, this will not be the case in relation to persons transferred from the criminal justice system to the CMH. There are three categories of prisoners transferred in this way: persons on remand or serving a sentence who become psychiatrically disturbed and who are transferred on medical advice; persons who are found by the courts to be 'guilty but insane'; and persons who, by a similar process, are found to be 'unfit to plead'. Though such persons are then involuntarily in the care of a psychiatric hospital and are subject to inspection by the Inspectorate biannually, review of their detention in the CMH does not come within the provisions of the current Mental Treatment Act nor the impending Mental Health Act 2001. Accordingly, there is no independent automatic mechanism in place for review of the appropriateness of their continuing detention in the CMH, although informal mechanisms may, and sometimes do, operate to deal with this matter.

Section 208, Mental Treatment Act 1945

The Inspectorate has some apprehension about the manner in which Section 208 of the current Mental Treatment Act is being used. It may be recalled from earlier reports that the Supreme Court deemed that the use of Section 208 to transfer persons from civil psychiatric in-patient facilities to the CMH was legal. The spirit of the section was that such transfers would be made to provide treatment for individuals in the CMH which was not available to them in their psychiatric hospital or unit of origin. The fact that some persons transferred under Section 208 have been in the CMH for a prolonged period of time, several years in some instances, seems at odds with the intention of the section as drafted. Section 208 is not, in itself, authority for the detention of a person transferred from a psychiatric hospital to the CMH. It is simply a power to transfer that person following completion of an appropriate reception order in the referring hospital under the provisions of the Mental Treatment Act 1945. It is essential, therefore, that CMH and the referring hospital ensure that the detention documents are current and up-to-date.

The practice whereby certain patients, having been transferred from prison to the CMH, are, at the expiry of their prison sentence, deemed by the CMH staff in need of ongoing care at the CMH and are detained there under Section 208 without prior non-voluntary admission to their own local psychiatric hospital at the expiry of their sentence, is inappropriate, and almost certainly illegal. Patients must be discharged from the CMH on the expiry of their prison sentence. If non-voluntary admission to the patient's local psychiatric hospital is deemed appropriate, an application should be made to have the patient admitted involuntarily, subject to the usual safeguards as set out under the Mental Treatment Act 1945. If, following admission, it is thought necessary to transfer the patient to CMH under Section 208, then the guidelines for this procedure as set out by the Inspectorate, and included as an appendix to this Report, should be followed.

Intensive Care Units

A national commitment to providing intensive care facilities for the disturbed mentally in all health board areas was recently announced as part of the Health Strategy and some health boards have already taken steps to provide such accommodation. It was expected that upgraded and new intensive care facilities would be provided by the Southern Health

Board at the former St Anne's premises in Cork and by the North Eastern Health Board at St Brigid's Hospital, Ardee. Other boards are actively planning the location and nature of their provision.

The Homeless Mentally Ill

With homelessness an increasing problem, there is acknowledgement that a proportion of homeless individuals also suffers from psychiatric disorder, particularly in the larger metropolitan areas. Because of this, there has been a commitment on the part of the Department of Health and Children to cater for this problem by the provision of specialised teams committed to both a residential and an outreach approach. During the year, a second consultant post specialising in the care of the homeless mentally ill was advertised and interviewed for by the Northern Area Health Board.

Liaison Psychiatry

Liaison psychiatry embraces the provision of specialised psychiatric services to general hospitals, both to their accident and emergency departments and to general hospital wards, where a substantial proportion of psychological problems are intertwined with physical illness. In recognition of this, the Department of Health and Children has created a number of full-time liaison consultant psychiatrist posts with back-up teams, notably in the major Dublin general hospitals, with a commitment to providing such services nationally. Where the general hospital is smaller, a part-time or 'special interest' liaison commitment is envisaged.

Alcohol-Related Problems in the Mental Health Services

The Inspectorate is disappointed that alcohol-related problems still constitute almost one-third of psychiatric hospital admissions despite the extensive provision of community-based alcohol treatment services. We reiterate our view that 'detoxification' from alcohol toxicity is inappropriate and, in severe toxicity, an unsafe procedure, in a psychiatric setting. Where toxicity is severe, with the likelihood of severe withdrawal symptoms and possible neurological complications, the safest place for such persons is on general medical wards, not in an isolated psychiatric setting. If, on the other hand, toxicity is of minor degree, the Inspectorate's view is that detoxification should be a primary care function. The Inspectorate has been struck by the number of people with 'alcohol problems' who remain needlessly in acute psychiatric beds, contributing in some cases to perceived acute bed shortages. It is also worth pointing out that the Mental Health Act 2001 specifically excludes involuntary admission of persons to psychiatric centres for addiction to alcohol alone, without accompanying mental illness.

Legal Status of Psychiatric Hospital Residents

Over the years, the Inspectorate has striven to reduce the number of persons remaining involuntarily detained who would more suitably be hospitalised on a voluntary basis. The practice still continues, although to a lesser extent. Because the provisions of the forthcoming Mental Health Act 2001 require that all non-voluntary detentions be automatically and periodically reviewed, and because of the workload that this will impose on mental health tribunals, the Inspectorate once again circulated all clinical directors, asking them

to request their consultants to review patients currently involuntarily detained, particularly those who were long-stay, with a view to changing their status from non-voluntary to voluntary where this was appropriate.

Rehabilitation

The importance of the issue of a specialised approach to rehabilitation of persons suffering from enduring mental illness, with its accompanying impairments and handicaps, has been recognised by the creation of consultant posts specialising in rehabilitation. The Inspectorate is particularly interested in monitoring the improvement in quality of life which should result from the enhanced input by specialised rehabilitation teams in alleviating the burden of chronic mental illness.

PROCEDURES AND PRACTICES

Complaints and Investigations

The Inspectorate receives a number of complaints each year from patients and relatives. Their numbers are relatively small. Whether this is because patients are unaware of the availability of central appeal procedures, or whether persons are generally satisfied with the services, is unclear. Patients have the right under legislation to write, without any censorship, to the Minister for Health and Children, the President of the High Court, or the Inspector of Mental Hospitals. The Inspectorate has been at pains to ensure that notices informing patients of these rights are prominently displayed in all in-patient locations and, in addition, that patients are informed of these rights on admission, both verbally and by means of information leaflets and booklets which the Inspectorate has indicated should be available in all hospitals and units. All complaints to the Department of Health and Children, including those from the Minister's office and from the office of the President of the High Court, find their way to the Inspectorate.

The majority of complaints come from patients contesting the legality and appropriateness of their non-voluntary admission to and detention in in-patient facilities. Others complain of the treatment they receive, the physical surroundings they find themselves in, and other matters. Complaints from relatives relate mainly to treatment and physical conditions of the in-patient setting. Each complaint is investigated individually and the clinicians and service providers in each instance are written to for their account of matters. In almost all instances investigated by the Inspectorate, non-voluntary admission and detention has been warranted in the interests of the individual's mental health. When complaints relating to dissatisfaction with treatment or physical surroundings are detailed, and if these have not already been referred to independently by the Inspectorate, they are brought to the attention of service providers, who are urged to improve matters. In addition to the mechanisms outlined above, the Inspectorate sees individual patients in hospital settings when requested to do so, and at inspection visits it is made known to patients that the Inspectorate is present and any patient so requesting is duly granted an interview. Notwithstanding this, some persons still feel aggrieved and, for some of these, no perceived appropriate redress seems to be immediately available under mental health legislation. Such individuals are informed of the mechanisms of appeal to the Courts, the Ombudsman and to professional regulatory bodies.

A small number of complaints in individual services are currently the subject of investigation. On completion, the reports of these enquiries are submitted to the Inspectorate, which then makes a decision as to whether any further action at central level is called for.

The Inspectorate regards it as critically important that patients are fully assisted and informed of the local complaints system. A system of monitoring to ensure that each complaint is handled in accordance with the complaints policy and procedure should be in place. At each location, a central complaints file should be maintained by the local management of the service, recording the nature of the complaint, name of complainant, method of dealing with the complaint, and outcome. A central complaints file should ensure that the service can audit complaints and identify general patterns indicating deficiencies in the service. In many of our interviews with selected patients, the majority informed us that they were not fully aware of their rights under the Mental Treatment Act 1945 or amending legislation, or of how to make a complaint if they felt aggrieved.

Risk Assessment and Management

Risk assessment is a gathering of information and analysis of the potential outcomes of identified behaviours and of identifying specific risk factors of relevance to an individual in the context in which they may occur. It involves linking a patient's history to current circumstances in order to anticipate possible future change.

Risk management is a statement of plans and an allocation of individual responsibility for translating collective decisions into action. The process, in addition to naming the relevant people involved in treatment and support, also identifies dates for reviewing assessment and management plans.

Risk assessment and risk management are relatively new issues in the context of Irish mental health services, but ones that need attention. Formal risk assessment documentation in relation to newly admitted patients, in relation to patients about to be discharged and in relation to staff-patient interaction is important and needs to be put in place. Accurate recording and accounting of historical information is a factor that needs to be carried into service development and delivery. Such endeavours are still in their infancy, but the Inspectorate is dedicated to promulgating and promoting them.

In this context, the Inspectorate is concerned with sudden deaths and alluded earlier in this Report to those that may be drug-induced or due to airway obstruction by foreign bodies. Another, and tragic, cause of sudden deaths is suicide; we regret to report that there were nine deaths of in-patients likely to have been suicide during the year (the inquests on all of them had not been completed by the end of 2001). Four of these deaths occurred on psychiatric hospital premises, the others occurred when patients were absent from the hospital, either on agreed parole or without leave. These 2001 figures compare with eleven patient suicides in 2000 and seventeen in 1999.

It is not our experience that suicides at local level are the subject of any formal audit and we strongly urge local services carefully to audit cases of suicide so that lessons may be learned to make risk assessment and management more potent and effective in the future.

An audit of a much wider gamut of activities and occurrences, such as aggressive incidents, should also be put in place. Audits of suicides and sudden deaths should not be restricted to in-patients and, because there is no formal statutory requirement on reporting deaths of patients in specialised psychiatric out-patient care, the Inspectorate is aware only of such deaths as are reported to it. Impressionistically, the number of such deaths would outweigh those of registered in-patients and therefore the case for their monitoring and auditing is self-evident. Good quality risk assessment must be integrated with good quality risk management as they are all part of the same process and, as risk is an integral part of the wider spectrum of good mental health care, difficult decisions around issues of serious risk should be based on collaborative information-sharing, discussions and consensus agreement on the immediate plan of action to be pursued, while at the same time recognising the existence of individual responsibility.

Accidents/Incidents

The Inspectorate enquired into the number of accidents, incidents and assaults on patients and staff on each visit of inspection. While all hospitals visited had a system of recording accidents and assaults, the system should be updated at some locations to facilitate appropriate study of the number of accidents by date, time and location. Details of recorded accidents, incidents and assaults were included in individual service reports.

Management of Aggression and Violence

Training programmes offered to staff on the management of aggression and violence within the mental health service varied widely in their extent and content. Some services had access to control and restraint instructors from within their own staffing resources, while others contracted instructors from the wider health services or from abroad. The Inspectorate had noted the diversity of providers and content of these courses and felt it important that a system of standardisation and monitoring to ensure the appropriateness of such courses be put in place.

It is the Inspector's view that, as far as the situation allows, any attempt to restrain aggressive behaviour should be non-physical. Where physical restraint is used, and it should only be used as a last resort, it is important that staff involved are adequately trained and deemed competent in its use. Similarly, all staff working in the mental health service should be adequately trained and competent in the use of de-escalation techniques for handling potentially violent situations and in break-away techniques in relation to personal safety. The Inspectorate has concerns relating to unregulated training courses and recommends the introduction of a set of approved national training standards, validated by a national training authority or by the new Mental Health Commission. This will ensure uniformity of approach throughout the country which, in turn, should ensure that all staff are competent in the skills mentioned above, in the best interests of patients and service providers.

Electro-Convulsive Therapy (ECT)

As in other years, the Inspectorate monitored the use of ECT therapy and facilities for the administration of ECT, in addition to documentary procedures and practices relating to this form of treatment.

Seclusion

The Inspectorate examined all facilities used for seclusion purposes. The number of patients placed in seclusion and the number of episodes of seclusion is included in the general comments in respect of each service inspected. Seclusion registers were adequately maintained at all locations, but it is desirable that seclusion orders be signed by consultant psychiatrists. Written seclusion policies, procedures and guidelines, in addition to medical and nursing notes relating to randomly selected seclusion episodes, were examined and commented on in all services where seclusion was used.

Similarly, the use of special nursing supervision and nursing observation levels were inquired into on each visit of inspection. Comments and recommendations, if appropriate, were included in each individual report.

A BRIEF OVERVIEW OF HEALTH BOARD SERVICES

EASTERN REGIONAL HEALTH AUTHORITY

There had been substantial population growth in this administrative area, covering the three constituent health boards of the ERHA. This has led to imbalances and discrepancies in the relationship between different area populations and funding arrangements, which had been established and continued in a traditional fashion before such population changes had occurred. These catchment area funding arrangements had been based on historical and traditional considerations, rather than on scientific exploration of need, so that the relationship between the two had become quite skewed in respect of individual services. A further challenge facing the ERHA is that of ensuring that all catchment areas have equitable access to the general hospital psychiatric units in the Authority's area of responsibility. This will necessitate the reviewing of existing catchment area populations [boundaries?], followed by whatever changes in them are deemed relevant. The putting in place of two new general hospital psychiatric units at Beaumont Hospital and St Vincent's Hospital, Elm Park, and the provision of greatly enhanced community services go some way towards meeting this challenge.

NORTHERN AREA HEALTH BOARD

In the St Ita's Hospital catchment area (Area 8) the urgent requirement was for the construction of an acute psychiatric unit at Beaumont Hospital for this service, the funding of which had long ago been made available. It was a source of irritation to the Inspectorate that progress on this project had been so slow. The Inspectorate also believed that the administrative arrangements for St Ita's Hospital should be so arranged as to provide separate administrative structures for the area mental health service on the one hand and the St Joseph's Intellectual Disability service on the other. The abolition of the current unitary structure would be to the benefit of both services.

The Area 6 service which, for so long, had been working out of totally inadequate acute in-patient premises at James Connolly Memorial Hospital (JCMH) and at St Brendan's Hospital, would shortly have the benefit of a new acute unit, currently under construction at that hospital. St Brendan's Hospital (Area 6) had now less than 200 patients and was

moving slowly towards closure as a generic acute admission unit. Given the unsatisfactory nature of the accommodation in what remained of St Brendan's, the Inspectorate was of the view that the sooner alternative service provision was made the better. Plans for the community residential deployment of residual patients in St Brendan's were well advanced, but there were considerable capital funding issues arising therefrom. The intensive care accommodation and other limited provision for more specialised purposes within the psychiatric services would continue to be provided from the residual land the health board was retaining on the St Brendan's campus.

The in-patient accommodation for the Area 7 catchment population was unsatisfactorily distributed between St Vincent's Hospital, Fairview, a free-standing psychiatric acute-care premises, and the limited acute in-patient accommodation at the Mater Hospital which, of its nature and practice, made little contribution to the overall catchment area needs.

SOUTH WESTERN AREA HEALTH BOARD

This health board provided three catchment area services, Areas 4 and 5, Area 3, and Area 9 (Kildare). The former currently provided acute in-patient services at Tallaght Hospital, including an as yet unopened six-bed unit for the later-life psychiatry service, and rehabilitation and residential accommodation for older persons at St Loman's Hospital campus. The existing structures at St Loman's were due for demolition and replacement by newer, alternative structures on the campus in addition to further more specialised provision for other needs. There was an urgent requirement for the replacement of the existing St Loman's structures which were in very poor condition. The catchment Area 3 service, based on the in-patient unit at St James's Hospital, had now sectorised and was working towards an increased community-based sector provision, notably a large day hospital premises on the South Circular Road. Considerable community infrastructural development was required in the Kildare service to reduce the pressure on bed usage at the Lakeview psychiatric unit, Naas General Hospital.

EAST COAST AREA HEALTH BOARD

This health board had responsibility for three catchment area services and the national forensic psychiatric service based at the Central Mental Hospital, Dundrum (which is commented upon separately in this report). The first of the three area services was that of catchment Area 2, currently based in a totally unsatisfactory in-patient unit at Vergemount Hospital, Clonskeagh. However, it was gratifying to record that the replacement acute unit for this service at St Vincent's Hospital, Elm Park, was currently under construction and was due to be operational by early 2003. It would replace both the Vergemount unit and the currently unsatisfactory St Camillus's unit at St Vincent's, Elm Park. However, substantial community development was necessary in this service. There was nothing new to report on the catchment Area 1 service, with its headquarters at Cluain Mhuire Family Centre at Blackrock and its in-patient base at St John of God Hospital in Stillorgan. The Co Wicklow service, based at Newcastle Hospital, remained unchanged since the Inspector's report of 2000.

MIDLAND HEALTH BOARD

The services provided by this health board covered Laois/Offaly on the one hand and Longford/Westmeath on the other. In the Laois/Offaly catchment area, a new acute psychiatric unit at Portlaoise General Hospital was virtually ready for occupation. However, an arrangement had been entered into whereby, to allow construction to proceed on the general wards at Portlaoise, accommodation in the psychiatric unit would be allocated to general medical patients for a four-month period, before the unit was handed over to the psychiatric service. The Inspectorate had been given assurance that this handover would take place as projected and without further delay. At Mullingar, substantial upgrading was under way in the admission unit in St Loman's Hospital. The Inspectorate is still most anxious that this element of the service should ultimately be provided in the general hospital at Mullingar. In the meantime, upgrading and remodelling of the board's premises at St Vincent's Hospital, Athlone, was proceeding and this would greatly benefit the psychiatric sector service with the provision of a new day hospital and sector headquarters on this site.

MID-WESTERN HEALTH BOARD

There were two psychiatric services in this health board. That for county Clare was on the brink of leaving Our Lady's Hospital campus in Ennis which had been sold to Shannon Development, with the transfer of the acute unit to Ennis General Hospital, and ancillary components of the service to new residential premises provided on the residual, retained land on the former Our Lady's campus. In Limerick, some intellectual disability patients from St Joseph's Hospital were transferred to specialised facilities at Lisnagry, with the resultant closure of the wards they had occupied in St Joseph's. Plans were proceeding towards the vacation of the remaining accommodation at St Joseph's and a premises had been acquired in Raheen to which older patients were to be transferred.

NORTH EASTERN HEALTH BOARD

There were three services provided by this board; that for Co Meath, which was currently linked to the Co Louth service at St Brigid's Hospital, Ardee, for administrative purposes. The Inspectorate was strongly of the view that the Co Meath service should become autonomous. Its main resource had been the acute unit at Navan General Hospital, which continued to function satisfactorily. However, community provision in the county needed to expand, although some extra provision had been provided in recent years. In Co Louth plans were to move the acute admission facility from St Brigid's Hospital, Ardee, to the Louth Hospital in Dundalk — a commitment which the Inspectorate warmly welcomed. Meanwhile, no plans were currently apparent for the transfer of intellectually disabled patients in St Brigid's to more appropriate accommodation.

In Cavan/Monaghan, extensive outreach and home-care programmes had been developed in association with primary care, which had resulted in a considerable diminution in the number of acute in-patient beds required, to the extent that the admission unit in St Davnet's Hospital, Monaghan, had become redundant. Side by side with the acute provision, both home and community-based, an intensive rehabilitation initiative had already become fruitful.

NORTH WESTERN HEALTH BOARD

The Sligo/Leitrim service, which had seen considerable community expansion in recent years, was awaiting its new acute unit in Sligo General Hospital, the construction of which was shortly to begin. In the Donegal service, there was still uncertainty concerning the future of the acute unit at Letterkenny General Hospital. All agreed that the current structure was quite outmoded for modern care and needed either upgrading or replacement. It was for the Board to decide which was more appropriate, having regard to the funding implications of either solution. Because of recent community-based residential acquisition, the existing long-stay patients in St Conal's Hospital in Letterkenny would shortly have the option of moving to this new accommodation and vacating the old hospital. The dilemma for the acute service was that of having to move back to the vacated accommodation in St Conal's to facilitate the building work required in the provision of the new or upgraded unit. Naturally, there was considerable apprehension about moving back from a general hospital location to the old mental hospital, even for a short period of time.

SOUTH EASTERN HEALTH BOARD

Four services were provided by this board. At Kilkenny, the major development had been the provision of the acute psychiatric unit at St Luke's Hospital, replacing the two admission units for Carlow/Kilkenny at St Dympna's Hospital, Carlow and St Canice's Hospital, Kilkenny. The new unit was completed by the end of 2001 and it was anticipated that it would open early in 2002 on completion of negotiations with representative organisations. Meanwhile, day hospital premises for the Kilkenny service were badly needed to avoid bringing so many patients back to St Canice's for day centre and day hospital purposes, as was currently the practice.

In Tipperary, the St Joseph's unit at Clonmel badly needed replacement but, towards the end of the year, the Inspectorate was gratified to hear that plans were being put in place for this. Intellectually disabled patients still continued to be cared for in St Luke's Hospital in conditions that were less than satisfactory; the Inspectorate was most anxious that alternative and appropriate accommodation and treatment centres should be found for them. Likewise, the Inspectorate awaited the opening of facilities for older persons and for day hospital and sector activity in the Cashel development. Community-based facilities were badly needed in the North Tipperary sector, responsibility for which had been transferred to the Mid Western Health Board, although in-patients from this sector still came to St Luke's Hospital, Clonmel.

At St Senan's Hospital, Enniscorthy, matters were still unsatisfactory in relation to acute bed provision. The Inspectorate was most anxious that this accommodation should be provided at Wexford General Hospital. The lack of day hospital provision in Enniscorthy was also a worry, as was the continued presence of intellectually disabled patients in St Senan's. There was little new to report in the Waterford service. Expanded day hospital facilities were required for the service to complement those currently provided.

SOUTHERN HEALTH BOARD

There was still a residuum of residential provision for patients in St Finian's Hospital, Killarney, some of it of poor quality and badly in need of alternatives. All remaining intellectually disabled persons moved earlier in the year to new, modern and more appropriate premises at Ballydibeen in Killarney. In the meantime, some re-orientation of residential rehabilitation accommodation in Killarney was under consideration. In north Kerry, extensive alternative community residential provision in Listowel was well under way at the time of the 2001 inspection, while in Tralee, a replacement day hospital for the old Caherina building was virtually complete.

County Cork provided four individual catchment area services. That of North Lee had moved its acute in-patient service to an acute unit in the Mercy Hospital late in 2000. The unit functioned well during 2001 but, being on the first floor, there were still some unresolved difficulties relating to an appropriate entrance foyer. By the end of the year, work had begun on converting the former acute premises of this service, located at St Anne's, Shanakiel, to intensive care and rehabilitation usage for the entire county. When completed, this would lead to the final closure of the last remaining vestiges of Our Lady's Hospital, currently of extremely poor quality, in the St Kevin's wards. In the South Lee service a programme of sectorisation had been undertaken and attempts were being made to acquire and develop community-based facilities for the sectors, so far unprovided.

Little progress had been made in moving the acute accommodation for North Cork from unsatisfactory premises in St Stephen's Hospital, Sarsfield Court. The Inspectorate once again urged that negotiations be undertaken, as a matter of urgency, with Mallow General Hospital with a view to providing an acute unit in that service. Apart from the new high-support residence in Mallow, there had been little community development in this service in recent years, although such initiatives were very badly needed. Finally, in West Cork the Inspectorate was told of plans to upgrade and improve community-based accommodation, notably in Bantry, and to reduce the number of patients admitted directly from this catchment area to St Kevin's Ward in Our Lady's Hospital without first being admitted to the acute unit at Bantry Hospital.

WESTERN HEALTH BOARD

There were four services in this board, for counties Mayo, Roscommon, East Galway and West Galway. In Co Mayo, the new psychiatric unit being provided by adaptation and reconstruction within Mayo General Hospital was now almost complete and the Inspectorate had the pleasure of visiting it during the year. It would, indeed, provide much better and more appropriate accommodation for acute purposes than the current St Teresa's unit in Castlebar. In the meantime, plans were in hand for the relocation of patients from St Mary's to St Teresa's and the ultimate vacation of the remaining occupied wards in St Mary's. In Roscommon it was found necessary to stress once again the need for a comprehensive day hospital in Roscommon town, a matter which is being pursued by the service in conjunction with improved facilities in Athlone for the southern Roscommon sector.

The psychiatric unit in University College Hospital, Galway (UCHG), badly needed refurbishment and upgrading and, in the view of the Inspectorate, a greater commitment to

sector-oriented work in this service would not go amiss. In East Galway, the acquisition by the health board of Portiuncula General Hospital was a step forward which the Inspectorate hoped will lead to the provision of an acute psychiatric unit in that hospital for the catchment area, even though considerable expenditure had led to remodelling of the current admission facilities in St Brigid's. There was still a major task to be faced in the rehabilitation of younger long-stay patients to be undertaken in St Brigid's and the creation of a consultant-led rehabilitation team should, the Inspectorate hopes, progress matters in this regard. Elsewhere in St Brigid's, approximately 150 older patients required an integrated and comprehensive programme for older persons, in conjunction with the specialised later life psychiatry services in East Galway. This should encompass, inter alia, their de-designation from the mental health service.

PRIVATE HOSPITALS

Private hospitals accounted for 14 per cent of admissions during the year 2000, and accommodated 15 per cent of the national total of resident patients on 31 March 2001. Two of the largest hospitals, St Patrick's and St John of God in Stillorgan, provided in-patient services for patients from around the country, mostly funded by private health insurance. St Patrick's Hospital had opened a new admission unit during the year and further improvements and renovations were under way. St John of God Hospital had almost completed its new admission unit by the end of 2001. The remaining, smaller, private hospitals catered, in the main, for older and longer-stay patients.

CHAPTER TWO

Eastern Regional Health Authority

EAST COAST AREA HEALTH BOARD

CLUAIN MHUIRE MENTAL HEALTH SERVICES — 2001 INSPECTION

INSPECTED ON 5 DECEMBER, 2001

GENERAL DESCRIPTION OF THE SERVICE

The population of the catchment area was 170,000 and it was not sectorised.

IN-PATIENT CARE

In-patient care was provided at St John of God Hospital, Stillorgan and nursing staff worked closely with Cluain Mhuire clinical teams. Forty-two beds were provided for public patients.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	2	10	18	5	—	35	85.36
3-12 Months	—	—	2	2	—	—	4	9.76
1-5 Years	—	—	1	—	1	—	2	4.88
> 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	2	13	20	6	—	41	100
% of Total	—	4.88	31.71	48.78	14.63	—	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	5	6	9	4	2
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
2	1	—	—	12	41

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	17	19	36
Temporary	3	2	5
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	20	21	41

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 417
Number of first admissions in 2000 99
Number of discharges in 2000 433
Number of deaths in 2000 2

Legal status of admissions
Voluntary 87.1%
Non-voluntary 12.9%

The number of admissions represented an admission rate of 2.45 per 1,000 of the catchment population. First admission accounted for twenty-four per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	35	384
Day Centres	2	120	314**
Out-patient clinics	2	1,700*	7,304***

*No. of out-patient clinics in 2000
**No. of persons registered
***No. of attendances in 2000

Community Residences

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

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
13	13.6	29	14.23	9.57

COST

The cost of the Cluain Mhuire Mental Health Service was £5.9 (€7.5) million in 2000.

GENERAL COMMENTS

Cluain Mhuire was the mental health service for Area 1 and it comprised a number of components. These included the acute in-patient component in St John of God Hospital, which is described in the St John of God Hospital report. A day hospital for the Cluain Mhuire/Area 1 service was also provided on the St John of God Hospital site. The administrative headquarters and out-patient clinics were both located in the Cluain Mhuire Family Centre, Blackrock and the rehabilitation service was located at Burton Hall and the community residential premises. The catchment area of almost 180,000 was quite compact and comprised a limited number of medical card holders. In effect, it was perceived by service providers as one sector and operated as such. The headquarters at Cluain Mhuire was essentially the sector headquarters and administrative centre for the entire service.

The day hospital at St John of God had become overcrowded and was unable to cope with the ever-increasing amount of work in the space available. The Inspectorate felt that

a new community-based location for a more extensive and comprehensive day hospital operation should be found and service providers agreed with this view. There had been some tentative suggestions that a site behind the Cluain Mhuire building might serve this purpose.

The Inspectorate was very impressed with the rehabilitative ethos that pervaded the multi-disciplinary teams. This was exemplified by the intensive programmes operating in Burton Hall and by setting up a new rehabilitation residence at Oropesa. Oropesa, together with the nearby Crannóg residence and Avila residence, provided a high standard of accommodation. The service did not have a specialised rehabilitation team and it was standard practice for all of the teams to follow their patients through the rehabilitation processes and structures. However, one consultant had overall responsibility, including a casting vote in relation to access to the residential facilities.

The Inspectorate was very impressed with the skill mix which pervaded all community work provided in this service and found it refreshing to see professionals from a wide variety of backgrounds united in their commitment to patient care. It was felt that other services could learn something from this approach which represented moving away from the stereotyped and stultifying vision of employing a limited range of mental health professionals. Unfortunately, this was the type of operation in most services. The service for older persons based in St Vincent's Hospital, Elm Park provided a service for catchment Areas 1 and 2. This arrangement appeared to work satisfactorily, even though the service did not appear to have admitting rights to the wards for older persons in St John of God Hospital, Stillorgan.

RECOMMENDATIONS

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

PSYCHIATRIC UNIT, VERGEMOUNT CLINIC — 2001 INSPECTION

INSPECTED ON 19 DECEMBER, 2001

GENERAL DESCRIPTION OF THE SERVICE

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

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

In addition, the Service Management Team administered the specialist Alcohol/Addiction service at Baggot Street Hospital.

IN-PATIENT CARE

In-patient care was provided at Vergemount Clinic where twenty-nine beds were provided in one male and one female unit.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	9	8	2	—	19	90.48
3-12 Months	—	—	1	1	—	—	2	9.52
1-5 Years	—	—	—	—	—	—	—	—
> 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	—	10	9	2	—	21	100
% of Total	—	—	47.62	42.86	9.52	—	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	14	1	5	—	—
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
—	1	—	—	—	21

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	8	8	16
Temporary	4	1	5
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	12	9	21

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 451
Number of first admissions in 2000 68
Number of discharges in 2000 450
Number of deaths in 2000.....1

Legal status of admissions
Voluntary.....94.7%
Non-voluntary.....5.3%

The number of admissions represented an admission rate of 4.9 per 1,000 of the catchment population. First admissions accounted for fifteen per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	45	1,165
Day Centres	1	25	20
Out-patient clinics	2	342*	907

*No. of out-patient clinics in 2000

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
2	12	1	14	1	14

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
15	8.5	64.5	49	12

COST

The cost of the Area 2 Mental Health Service was £6.4 (€8.1) million in 2000.

GENERAL COMMENTS

The Area 2 Mental Health Service provided services for a catchment area with a lower than average proportion of medical card holders. It was notionally divided into three sectors. A small section of the territory had transferred to the South-West Area Health Board and now belonged to catchment Area 3. However, the logistical difficulties for patients from this segment making their way to the Area 3 services were so great that common sense suggested it should remain part of the Area 2 service. Because of the compactness of the geographic area, a case was made by the service providers that it would be uneconomic and unnecessary to provide sector headquarters and day hospitals in all three sectors. While not disputing this, the Inspectorate pointed out that, as things stood, there was no satisfactory community base or mental health centre in the entire service and this needed to be remedied whether through an enlargement at the Glenmalure Day Hospital premises or elsewhere.

The acute unit at Vergemount was well maintained, clean and tidy. There had also been some improvements made to the unit during the past year with more to come. However, it was clearly unfit for its purpose. A replacement psychiatric admission unit at St Vincent's Hospital, Elm Park was under construction and was likely to be ready for occupation in late 2003 or early 2004. When this occurred, the acute unit at Vergemount Clinic would become a residential rehabilitation unit. Two additional units on the campus of Vergemount, Whitethorn and De Brun, were originally used for the care of older, long-stay

patients from St Brendan's Hospital. Although never designated for psychiatric care, the units were staffed by nurses from the Area 2 Mental Health Service.

At the time of inspection, the De Brun unit was being used as a continuing care unit for the later-life psychiatry service for Area 2. The consultant in later life psychiatry, whose in-patient base was St Camillus Unit in St Vincent's Hospital, Elm Park, was in charge. When the new acute psychiatric hospital opened, the later life psychiatry service would acquire acute assessment beds in that unit. The Whitethorn unit comprised a mixture of continuing care beds for older persons (again under the care of the Area 2 later-life psychiatry service) and younger, continuing care patients from the adult psychiatric service who were cared for by the Area 2 adult mental health service. The medical needs, as distinct from the psychiatric needs, of patients in these units were provided through the Area 2 mental health service. The Inspectorate felt that this was anomalous and believed that general medical requirements should be provided by the medical staff who provided this care to other patients on the Vergemount campus. It was unsatisfactory that older patients from the specialised later life psychiatry service should mix with younger patients from the general adult psychiatry service in the Whitethorn unit. When the acute unit becomes a residential rehabilitation unit, these younger patients should transfer there.

The Area 2 service had limited accommodation in Baggot Street Hospital which was used for out-patient clinics. It would be a considerable step forward if that accommodation could be enlarged to provide a sector headquarters and day hospital for that sector of Area 2. If plans to provide a sector headquarters at the Glenmalure Day Hospital site materialised, there would then be two community mental health bases with day hospitals in both Baggot Street and Milltown. The community residences inspected in 2000 and 2001 were of a high standard and were well maintained. The service had purchased a substantial bed and breakfast premises on Morehampton Road which was to be used as a high-support residence.

Some nursing posts in the service were still unfilled which often led to shortages in various components of the service. Successful overseas recruitment had helped alleviate the problem but had not brought numbers up to the establishment complement. As a result, some patients in the acute unit reported that they were not getting the degree of individual care they expected from the nursing staff and were unable to identify their own primary nurse in some instances. Patients also complained of lack of privacy in various locations of the service and particularly in the bathroom areas. There were four established occupational therapy posts in the service but only two were filled at the time of inspection. Similarly, only two social workers were employed and no psychologists were employed in either of the three teams. It was also noted that there was no permanently appointed consultant psychiatrist in the service. These matters required some attention.

An annual report was produced for the Glenmalure Day Hospital which set out developments that occurred in 2000, training undertaken by staff, and plans and objectives for 2001. The day hospital had an attractive information leaflet for patients which set out the aims and objectives of the day hospital with a brief description of the therapeutic programmes on offer. A separate information guide was available for reference purposes.

Similar reports and information guides should be available in other areas of the Area 2 Mental Health Service. Health & safety committee meetings were held each month and minutes of the meetings were kept. There was a fire register with the names of all staff participating in fire training and evacuation procedures. Separate detailed records of all in-service training for nursing staff were kept.

The drugs policy and procedure was reviewed in April, 2001. Most prescriptions examined were in block letters and those that were scripted were easy to read. Prescriptions were signed and dated individually. Space was provided on the prescription cards to record drug allergies to ensure such information was rapidly available to staff. Discontinued drugs were not always signed off using the discontinuation column and a number of cards examined had a greater number of discontinued prescriptions than current prescriptions. These cards should be rewritten as there was an increased risk of drug error in administration. In some instances, the day and month of the prescription was recorded but the year was not. This required attention.

The 'Roper Model' of nursing was the nurse care planning system in operation. There were plans to review this model with a view to updating or replacing it. All entries in the existing system were made as soon as possible after the events to which they related. Entries were accurately dated but the time of entry was not recorded. The service agreed to audit the nursing records to access the standard of record-keeping and to identify areas for improvement and staff development. Ideally, nursing records should reflect the involvement of patients in planning and making decisions about their own care and treatment. Entries should include patients' wishes, preferences and suggestions about treatment approaches. Similarly, nursing evaluations should include patients' views about progress. As a number of abbreviations were noted in the records examined, a written policy on the use of abbreviations was required. There should be an input in the nursing record to indicate how well a patient settled into the ward at the end of their first day of hospitalisation.

A number of clinical files were examined and the overall standard varied. Written instructions on filing documentation within the clinical records was required. There was a system of sequencing clinical notes but this was not followed on every file examined. Provision was made for recording a patient's name on each continuation page but this was not always done. Whilst all entries were signed, some of the signatures were illegible. Ideally, all entries should be dated with the time of entry and signed legibly and in full. The designation of the professional staff member should also be recorded. Progress notes by social workers, psychologists, occupational therapists and other professionals should be easily accessible in patients' case notes. Record folders had an open pocket on the inside rear cover and some contained copious amounts of clinical material. Risks associated with loose material included delays in accessing pertinent information and misfiled information as the contents were not secure.

Seclusion was not used in the service but there were 939 episodes of special one-to-one nursing supervision involving fifty-eight patients in 2000. None of the patients admitted involuntarily had their temporary orders extended during 2000. Thirty-eight accidents to

patients, eleven assaults on patients by other patients and twenty-seven assaults on staff were recorded. None were deemed serious. Twenty-three patients were prescribed ECT and these facilities were satisfactory. Documentary procedures relating to ECT were also satisfactory. Thirty-seven patients discharged themselves against medical advice in 2000 and follow-up procedures were in place if considered clinically appropriate.

Three patients were interviewed to ascertain their views on the level of service provided. One female patient with a number of previous admissions was very satisfied with the courtesy and helpfulness of staff. She was introduced to her consultant psychiatrist and the key nurse assigned to her on her admission. Her consultant was known to her from previous admissions but she could not recall the name of her key nurse. She attributed this to the fact that nurses were scarce or too busy and there was a constant change in personnel. The nature of her illness, her medications and their side effects had all been explained to her and she had a reasonable understanding of what was explained. Whilst she had a number of criticisms to make, she realised that none of them was the fault of the doctors or nurses. For example, she decried the lack of privacy in the ward; there was inadequate space to talk privately with visitors or to make phone calls. She was critical of the toilet and bathroom areas where faulty equipment, lack of partitions etc. produced unsatisfactory conditions. She was unhappy with the quality of food; there were too many cold dishes and salads and not enough hot, well-presented meals. The sleeping arrangements were reasonable but noisy patients woke her up frequently. When asked how she would like to improve the ambience of the unit she suggested 'it should be replaced'. She reiterated that the staff were very good at attempting to make the place cheerful and often succeeded despite it being a constant struggle for them. She particularly appreciated the positive attitude of staff towards patients.

The second patient was involuntary. He was disgruntled on admission and didn't want to pay any heed to the doctors or nurses. However, he felt more content now. He knew his consultant psychiatrist and saw him twice a week. He did not know the name of the key nurse assigned to him but knew them to see. Like the first patient, he said there were not enough nurses, those present always busy and the personnel changed regularly. Despite these shortcomings, the nurses always found time to talk to him. He spoke highly of the attitude of all staff towards patients and his main complaints were about general conditions such as ''shabby food'', lack of privacy and a lack of space generally. He particularly decried the lack of privacy for making phone calls; his conversations could be overheard by other patients. He was satisfied with hygiene levels in the toilets and bathrooms and was also satisfied with the sleeping arrangements. He would like improvements in the general décor of the unit. He said the atmosphere in the ward was quiet enough and he had become quite friendly with fellow patients. He had never experienced the use of illegal drugs. Despite the fact the Rights of Patients under Mental Treatment Legislation was publicly displayed in the Unit, his attention was never drawn to them but he recalled having read them in another psychiatric hospital. Apart from his disquiet on admission, he was quite positive about the services provided.

The third patient was an older voluntary patient who had nothing but praise for the nursing and medical staff. She knew her consultant psychiatrist and spoke with him frequently. While the nurses were very attentive to her, like the other two patients, she

couldn't recall the name of her key nurse and she also disliked the discontinuity in nursing due to staff shortages, use of agency nurses etc. She too disliked the lack of privacy in the bathroom and toilet areas and was not happy with the presentation of food. She found the day long and boring. She was not interested in occupational therapies and her underlying depressed mood probably explained why she felt this way. When asked what she thought should be done to improve her stay in hospital she replied ''everything needs improving''. While the underlying psychological problems of the three patients tended to colour their opinions, there was no doubting the obvious unsuitability of this unit as a comprehensive psychiatric facility despite the immense efforts of the staff to maintain standards.

RECOMMENDATIONS

It is recommended that:—

1. All the necessary negotiations and arrangements for the transfer of acute services from Vergemount Clinic to St Vincent's Hospital, Elm Park be progressed so that there are no delays moving from the one location to the other as soon as the new unit is ready.
2. Consideration be given to setting up community mental health centres and day hospitals in Glenmalure, Milltown (where the existing day hospital needs to be physically enlarged and range of patients with which it copes enhanced) and Baggot Street Hospital.

CENTRAL MENTAL HOSPITAL — FIRST 2001 INSPECTION

INSPECTED ON 4 APRIL, 2001

GENERAL DESCRIPTION OF THE SERVICE

The Central Mental Hospital (CMH) provided a forensic service for the entire country with a population of approximately 3.5 million. The service was funded by the Eastern Regional Health Authority and administered by the East Coast Area Health Board.

IN-PATIENT CARE

In-patient care was provided at the eighty-one bed Central Mental Hospital, Dundrum.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	12	—	—	—	12	15.19
3-12 Months	1	—	14	1	—	1	17	21.52
1-5 Years	—	—	15	2	—	—	17	21.52
> 5 Years	—	—	10	19	2	2	33	41.77
All Lengths of Stay	1	—	51	22	2	3	79	100
% of Total	1.27	—	64.56	27.85	2.53	3.79	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
1	48	11	3	5	—
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
6	—	—	4	1	79

Status of in-patients at 31.12.00

Status	Male	Female	Total
Remand	13	2	15
Guilty but Insane	19	—	19
Unfit to Plead	4	—	4
Section 208	12	3	15
Section 207	8	—	8
High Court Order	—	1	1
Sentenced	17	—	17
Total	73	6	79

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 185
Number of first admissions in 2000 89
Number of discharges in 2000 192
Number of deaths in 2000 2

Legal status of admissions
All involuntary patients in the CMH

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	—	—	—
Day Centres	1	10	103
Out-patient clinics	4	570*	4,400**

*No. of clinics held in 2000
**No. of attendances at the clinics

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
9.5	6	120	16.5	4

COST

The cost of the Central Mental Hospital service was £6.6 (€8.4) million in 2000.

GENERAL COMMENTS

The CMH, the national forensic psychiatric hospital, admitted patients from the criminal justice system and from the psychiatric services under the provisions of the Mental Treatment Act, 1945. In addition to in-patient care, the hospital provided a consultative assessment service for hospitals throughout the country and the criminal justice system. An out-patient facility was located at Usher's Island, Dublin 8. The service was managed by a tripartite management team of Clinical Director, Director of Nursing and Area Manager and regular monthly meetings were held to decide hospital policy and to review current best practice.

Apart from some minor redecorative work in the day room in Unit 1 and the acquisition of furniture, very little had changed at the CMH since the previous inspection. Units 2, 3 and 6 were vacant and units 2 and 3 had been extensively redecorated and renovated and there were plans to relocate patients from Unit A and Unit 5 to these locations. The female patients in Unit 4 were to relocate to Unit A. This would facilitate upgrading part of the old hospital building. The sleeping areas in the old building were of poor quality, lacked adequate furnishings, had peeling walls and had either limited or no clothes storage. All of the sleeping areas had night pots with the accompanying practice of slopping out in the mornings. All of this was unsatisfactory. The relocation of Unit 2, Unit 3 and the female unit was seen as a short-term measure to improve overall physical facilities.

The East Coast Area Health Board had established a group to review the future role of the CMH. The group was sitting at the time of inspection and would advise on proposals for the future of the CMH in the context of national and regional services provided by the hospital, linkages with community psychiatric services, linkages with the criminal justice system, legislation, training role of the CMH for medical, nursing and paramedical staff and future accommodation and resource requirements. It was expected that the group would submit its report to the Chief Executive Officer of the East Coast Area Health Board. The health board was committed to providing a modernised forensic mental health service for the Eastern Region and the country as a whole.

The CMH admitted approximately 160 patients per year, the majority from the prison system. This constituted 1.37 per cent of all committals to prison (11,620 per annum), the highest proportion in any European state. Approximately 2,900 prison places were occupied at any given time. Problems for the prisons relating to mental health included the detection of those with mental illness, the prevention of suicide and the reduction of harm due to drugs and alcohol. In addition to in-patient services based at the CMH, consultant-led liaison services and out-patient clinics were provided to the Dublin prisons. Additional forensic psychiatrist posts had been approved with a view to providing in-reach services within the prisons so only those with severe mental illness and in need of appropriate hospital care would be transferred to the CMH. Providing the in-reach services in the prisons should facilitate patient access to services equivalent to local services even while

in prison custody. A needs assessment for all patients hospitalised in the CMH was underway at the time of inspection. When completed, this assessment would identify the requirements of those patients already in secure care.

There was a lack of distinction between high, medium and low security facilities within the CMH. Units with higher staffing levels were not sufficiently secure in their physical structure which led to an over-reliance on the use of seclusion. As a result, patients requiring medium or low security could find themselves in the same unit as those requiring high security. This was not very satisfactory. A substantial development of the hospital environment was required to provide separate high, medium and long-term low security accommodation. It was possible to do this within the CMH campus and still provide adequate facilities for patients to exercise, work, sport and rehabilitation.

One of the most pressing service developments at the CMH was to upgrade the old building in order to provide additional day space and in-room sanitation for patients. As mentioned in previous reports, the in-patient facilities in Units 1, 4 and 5 were unsatisfactory. The seclusion room in Unit 4 was old-fashioned, grim and unacceptable. However, it was noted that this area was due to close once the patients relocated to Unit A. There had been an overall improvement in the standard of Unit 7, particularly with regard to ward hygiene. There had been much talk about upgrading the CMH for a number of years with little or no progress. All of the units in the old building had changed little since their construction in 1850, and despite some minor redecorative work, serious deficiencies remained in terms of accommodation, sanitation and recreational facilities.

The quality of accommodation for long-stay patients in the hostel on the hospital grounds was excellent. The house was of good quality, comfortable with appropriate furnishings and a homely atmosphere had been achieved. The house itself required some internal redecoration but overall the facilities were satisfactory. Serious consideration should be given to providing similar accommodation for other appropriately selected long-stay patients in the CMH in order to facilitate their rehabilitation and eventual discharge to independent living or community residential accommodation.

There were 900 episodes of seclusion involving 191 patients in the CMH in 2000. While the number of episodes of seclusion had reduced marginally, the number of patients placed in seclusion had increased from forty-nine patients in 1998 to seventy-seven in 1999 and to 191 in 2000. While a seclusion policy was available in the hospital, an audit of its implementation was required. Seclusion authorisations were mainly prescribed by junior doctors. A seclusion register was maintained at all locations and fifteen-minute nursing observations of all patients placed in seclusion were maintained and appropriately recorded. There were 990 spans of special one-to-one nursing supervision involving sixteen patients in 2000. Guidelines or procedures relating to the use of special nursing should be incorporated into the hospital policy and procedures manual. One patient was prescribed ECT. Six patients under Section 208 of the Mental Treatment Act, 1945 had their temporary admission orders extended during 2000. During 2000, nineteen accidents to patients

and twelve accidents to staff were recorded. Four accidents required further medical intervention. There were ninety-two recorded assaults on patients by other patients and thirty-one recorded assaults on staff. Eleven patients and five staff required further medical intervention.

A marked increase in staff morale was noted on this inspection. Upgrading of the former Units 2 and 3 to facilitate the relocation of patients had a very positive influence on morale as had the planned refurbishment of the old building and the commitment of the East Coast Area Health Board to bring about these changes. The hospital had only one part-time psychologist and one psychiatric social worker. The number of professional staff allied to medicine needed to be strengthened in order to provide a true multidisciplinary team approach for patients utilising the service. The appointment of two further consultant forensic psychiatrists with multidisciplinary team support had been approved by the health board and negotiations were proceeding with Comhairle na nOspideal with a view to commencing the recruitment process in summer/autumn, 2001. With these appointments, the service should consider strengthening its out-patient component which would include an in-reach service to the prisons as already mentioned and which should include residences administered by the forensic service for suitably selected patients.

A written drugs policy and procedure was available in each local area. A number of prescription cards were examined and the standard varied. Discontinued prescriptions outnumbered current prescriptions on a number of the cards and this led to an increased risk of error in administering drugs. These prescription cards should be rewritten. The prescription cards examined were all scripted but they were not difficult to read. All prescriptions should be signed in full by the person prescribing and they should be dated individually. Discontinued drugs should be signed off using the discontinuation column. Prescribed medication was recorded in the patients' case notes. Information should be supplied to patients, ideally in written form, about their medication and treatment so that an informed choice could be made by them. Records of verbal information given to patients in relation to medication or treatment should be recorded in the case notes.

An information booklet with information pertinent to a patient's stay in the CMH should be available for patients and their relatives. Health and safety statements were available at each clinical location and safety audits had been completed prior to the inspection but records of hazard control analysis were not available in each local unit. Fire drills and mock evacuation procedures took place each week at all locations and appropriate records were kept. Fire precautions generally within the hospital were satisfactory.

The nursing records across the entire hospital were in the form of ward progress reports. These needed to be audited to assess the standard of the records and to identify areas for improvement and staff development. A modern nurse care planning system should be introduced using an agreed model of nursing care and a primary nursing system should be introduced on a phased basis with each patient allocated a nurse directly responsible for their care on a day to day basis. The primary nurse should be responsible for nursing care plan documentation and for the presentation of clinical aspects of a patient's condition at multidisciplinary review meetings. The new nursing care plan should reflect the

involvement of patients in planning and making choices and decisions about their care and treatment and should include entries of a patient's wishes, preferences and views on their progress.

A number of clinical medical files were examined on the inspection and the overall standard of the files varied. Some files were excellent and were legible and easy to follow. The reason for admission was clearly documented as was the presenting complaint, past history, personal history, family history, mental state examination, physical examination and current medication. A summary of the assessment and a clear immediate management plan was recorded. Some notes were difficult to follow and the full signature of the person making entries in the notes should be recorded. Although the date of entry was recorded, the time should also be clearly recorded. The patient's name should be recorded on each continuation page and written instructions on the filing of documentation within the record were required.

Under existing legislation, patients could be transferred from psychiatric hospitals under two sections of the Mental Treatment Act, 1945; Section 207 and Section 208. Section 207 allowed for such transfers if the detained patient committed an indictable offence and following a judicial process was certified by the presiding judge as being suitable for such a transfer. This section was no longer used. Nevertheless, there were still eight Section 207 patients at the CMH.

Section 208 allowed patients to be transferred to the CMH from local psychiatric services if it was felt the latter did not have appropriate facilities to treat them. Such transfers became possible following a Supreme Court judgement (April 1994). These patients were generally those who were considered a danger to themselves or others because of their mental illness. Up to the time of the Supreme Court Judgement, Section 208 had never been used for this purpose. Following the judgement, however, the Inspectorate considered it prudent to issue guidelines for the transfer of patients to the CMH under the provisions of Section 208 and these guidelines were issued to each psychiatric hospital in the country. The guidelines were intended to prevent abuse of the transfer system as the judicial process needed under Section 207 did not obtain under Section 208. Fourteen Section 208 patients were in the CMH on the day of inspection.

Some disquieting features were noted in the case notes of these patients. Firstly, the guidelines as issued by the Inspectorate did not appear to have been used or if they were used the appropriate transfer forms as suggested by the Inspectorate were not completed and hence not copied to the Inspectorate as advised. Secondly, there appeared to have been little or no formal liaison between the referring hospital personnel and that of the CMH during the patients' stay. Such liaison should exist so that patients could be discharged from the CMH at the earliest opportunity. Thirdly, and more significantly, a worrying practice appeared to have developed whereby patients admitted to the CMH from the prison services, on reaching the end of their sentence and not having been deemed fit for discharge, were placed on a temporary detention form and sent to an

appropriate mental hospital — usually St Brendan's Hospital, Dublin. Section 3 of the temporary forms were then completed and the patients were returned to the CMH under Section 208 of the Mental Treatment Act, 1945.

RECOMMENDATIONS

It is recommended that:—

1. Procedures relating to the transfer of patients under Section 208 of the Mental Treatment Act, 1945 and amending legislation, as set out in the Guidelines on Good Practice issued to the Health Board, be followed.
2. Additional consultant forensic psychiatrists be employed with a view to providing enhanced assessment and treatment facilities to the prison service and to develop an out-patient forensic service initially in the ERHA region.
3. The local management plan to relocate female patients to Unit A and male patients to the newly decorated Units 2, 3 and 6 be expedited.
4. The hospital accommodation in the old building be modernised and brought up to an acceptable standard with the provision of in-room sanitation and enhanced day and recreational facilities for patients.
5. The residence on the hospital grounds be redecorated and the service explore the feasibility of providing additional low secure residential facilities on campus.
6. Attempts be made to reorganise wards, ward staffing and mix of patients with a view to providing a graded structure of care with security geared at levels of high, medium and low to meet the appropriate needs of patients.

CENTRAL MENTAL HOSPITAL — SECOND 2001 INSPECTION

INSPECTED ON 4 DECEMBER, 2001

GENERAL COMMENTS

There were eighty-one patients in the Central Mental Hospital (CMH) on the day of inspection. Six were female. Sixty-one came from the criminal justice system; twenty-one were remand patients, eighteen were guilty but insane, sixteen were sentenced and five were unfit to plead. The guilty but insane and unfit to plead patients were older and longer-stay than the remand and sentenced patients. Patients from the mental health system comprised fourteen Section 208 patients and seven Section 207 patients. The Section 207 patients were in the CMH for longer periods than the Section 208 patients. The longest-stay patient had been there for fifteen years. Some of the Section 208 patients tended towards chronic illness and a number of them had been in the CMH for more than five years.

A review body to plan the future of the CMH had concluded its work and its report had gone to the Eastern Regional Health Authority for submission to the Department of Health and Children. This report and survey included plans to modernise and refurbish the old building. New additions and extensions to the existing building and a new residence was to be provided on the campus outside the security perimeter. Overall capacity was expected to increase from ninety to 120.

While it was unclear when work on this project would commence, the Inspectorate felt it absolutely essential that it start as soon as possible. At the time of inspection, there was no concrete indication of when the improvements to the CMH would occur. Most of the old building was quite unsatisfactory for its current purpose and conditions in some parts of it were most unsatisfactory. The archaic seclusion accommodation in Unit 1 was unfit for a mental health institution of the twenty-first century and this had been highlighted by the Inspectorate on previous occasions. Similar limitations applied to the seclusion and general sleeping accommodation in the female unit, Unit 4. Conditions elsewhere in the old building, apart from the possible exception of Unit 7, were little better. Patients were locked into rooms at night and had to 'slop out' in the morning. The new units, A and B, provided better accommodation but, with the cramped floor area and low ceilings, even this building was somewhat intimidating.

The culture of seclusion was deeply embedded in the CMH. Seclusion was practised in four units and appeared to be endemic in Units 1 and 4. Unit 1 seemed to have at least one patient in seclusion almost every day. Seclusion was often used by nursing staff and only authorised retrospectively by junior doctors who, when eventually contacted, signed the appropriate seclusion book. There were instances when even this minimal compliance with the regulations did not take place. Sometimes episodes of seclusion were recorded in some detail in medical case notes, at other times they were not. The Inspectorate was told that this matter of documenting seclusion was improving with the increase in medical staff and, with the arrival of new consultants, would further improve. Nursing notes for seclusion episodes were generally satisfactory. A new seclusion policy was introduced in May, 2001 and it included a detailed seclusion audit which was carried out by staff on the ward and brought to the office of the Director of Nursing. These were welcome developments but there had still been 602 episodes of seclusion up to the end of September 2001. It raised the questions with regard to standards and quality of care in wards with an inadequate skill mix among staff, insufficient treatment and intervention programmes compounded by unsatisfactory environmental conditions.

The quality and organisation of case notes was mediocre but attempts were being made to put in place a planned approach for each new arrival in the CMH with intake conferences and exit strategies being put in place. This would be more feasible with the recruitment of extra consultants which would bring the total number employed to five. The consultants would constitute the basis of multidisciplinary teams with each consultant responsible for a team comprising social workers, psychologists and occupational therapists. Only one psychologist and one social worker were employed at the time of the inspection and difficulties recruiting suitable staff had been experienced.

Recruitment difficulties also extended to nursing staff. There were 127 established nursing and care staff posts and at the time of inspection there were twelve vacancies and a number of persons on long-term sick leave. This reduced the effective staff complement to borderline level for security and therapeutic purposes. An attempt had been made some years ago to change the skill mix in favour of nursing staff with the recruitment of new nurses and seconding care staff to nurse training. This initiative, while initially successful, had stalled in recent years. It was proving difficult to recruit new nursing staff to the service for a variety of reasons including the disparity between nursing and care staff remuneration terms.

The number of Section 208 patients, comprising approximately twenty per cent of patients in the CMH, was disquieting, particularly as some of them had become long-stay patients. Staff had difficulty repatriating these patients to their parent mental health services. As a result, they were naturally reluctant to take more patients under Section 208 from the mental health services. Similar difficulties had been experienced in relation to some Section 207 patients and even though individuals in both groups were deemed fit to return to their parent services they remained in the CMH with resultant infringements of their civil rights.

Procedures to report incidents of assaults on staff and other incidents involving patients as well as the use of control, restraint and seclusion had been put in place. Attempts to improve other documentary and reporting procedures were being made. The introduction of electronic methods of data capture and recall in relation to details of patients' treatment, etc. were being pursued. There was concern that, in certain instances, procedures relating to Section 208 patients who remained the certified 'property' of their parent hospitals were inadequate. Some patients needed to have their temporary patient reception orders extended when their current one expired. These orders remained in the parent hospital and, if they were not extended or the patient was not re-certified, there would be a situation where such temporary patients would be held illegally in the CMH.

Consultants highlighted the fact that in some cases where the CMH had gone to court to seek an order to return a Section 208 patient to their hospital of origin as a result of the refusal of that hospital to repatriate the patient, neither the CMH nor the parent hospital intensive care unit offered satisfactory accommodation for the patients in question. It was the consultants' view that a medium-secure unit was necessary, somewhere between the level of security offered at the CMH and the intensive care units offered by mental health services. Given that some of the patients were of borderline intelligence, and therefore came within the remit of the intellectual disability services, the need for a specialised unit for such people within those services was again stressed.

Earlier in 2001, a survey of patients in the CMH was carried out. Seventy-three of the eighty-eight patients in the hospital at the time responded and gave their views on a wide range of issues. Boredom during the day and limited interaction with staff members emerged as particular problems. The recreational, educational and occupational facilities catered for up to one-third of patients during the day. However, patients regarded this as insufficient and wanted to see the facilities expanded. It was hoped to deal with this matter

by extending the area available for such activities and increasing the personnel involved. This could be put in place with the reorganisation of the hospital. The existing Units A and B would not form part of the new CMH and could be used for this purpose. However, competition for this space was likely to be intensive. One suggestion had been made to use it as an assessment centre for long-term prisoners, many of whom were suffering from major psychotic illness which had gone untreated or been inadequately treated in the prison service. It was also felt that the policy of admitting persons from the prison service had shifted to dealing with people with more severe illness. As a result, acute crisis-type admissions of prisoners with environmental stress disorders which led to self-harm or short-lived depressive episodes were now less likely. Such persons were more effectively dealt with within the existing prison system.

Prior to refurbishing the old building, some movement of patients within the CMH had to take place. Some empty units had been redecorated for this purpose but, to date, none of the patients had moved. Attempts were being made to put a professional structure on ward management and staffing from a nursing perspective. While the commitment to this was unequivocal, progress had been relatively slow because the culture and traditions of the CMH were proving difficult to change. An attractive brochure had been designed to attract new nursing recruits to the forensic service. Difficulties experienced by all mental health services in the Dublin area were shared by the CMH and impeded the initiative. The Inspectorate was told that the clerical infrastructure at the CMH was seriously under-staffed and needed to be strengthened substantially if all the documentary procedures referred to above were to be implemented.

RECOMMENDATIONS

It is recommended that:—

1. Building work recommended by the planning group to modernise and refurbish the unsatisfactory in-patient care areas of the Central Mental Hospital commence as soon as possible.
2. Patients residing in Units 4 & 5 relocate to upgraded facilities in Units 2 & 3 and Unit A.
3. Seclusion audits continue with a view to reducing the number of seclusion episodes and improving documentary procedures relating to its use.
4. The seclusion rooms in Unit 1 and Unit 4 close.

PSYCHIATRIC UNIT, ST VINCENT'S HOSPITAL, ELM PARK — 2001 INSPECTION

INSPECTED ON 5 DECEMBER, 2001

GENERAL DESCRIPTION OF THE SERVICE

The psychiatric service at St Vincent's Hospital, Elm Park did not have a catchment area.

IN-PATIENT CARE

In-patient care was provided at the twenty-two bed St Camillus psychiatric unit, St Vincent's Hospital, Elm Park. Three beds were reserved for the eating disorders programme, four for the psychiatry of later life service, three for direct admission from the A&E Department (usually for drug overdoses) and two for the National Maternity Hospital, Holles Street.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	7	1	1	3	12	85.71
3-12 Months	—	—	1	1	—	—	2	14.29
1-5 Years	—	—	—	—	—	—	—	—
> 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	—	8	2	1	3	14	100
% of Total	—	—	57.14	14.29	7.14	21.43	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
1	1	—	6	1	3
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
1	—	—	—	1	14

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	3	11	14
Temporary	—	—	—
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	3	11	14

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 373
Number of first admissions in 2000 133
Number of discharges in 2000 372
Number of deaths in 2000 0

Legal status of admissions
Voluntary 98.4%
Non-voluntary 1.6%

DAY FACILITIES

	Number	No. of Places	No. of persons attending
Day Hospitals	1	40	132
Day Centres	—	—	—
Out-patient clinics	1	195*	Not available

*No. of out-patient clinics held in 2000

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
8.1	3.5	25.66	2	2.25

COST

The cost of the St Vincent's Hospital service was £1.4 million (€1.8) million in 2000.

GENERAL COMMENTS

St Camillus Psychiatric Unit was a stand-alone twenty-two bed unit in St Vincent's Hospital, Elm Park. It did not form part of the wider catchment area service although it did admit patients from part of that catchment area and from further afield for its specialised eating disorders programme. The unit was limited in the space available to it and it provided only a very limited community service. It was to be replaced by a new comprehensive acute psychiatric unit for the catchment area 2 service. The new unit was under construction and would also replace the unsatisfactory admission unit in Vergemount Clinic. It was expected to be ready late in 2003 or early in 2004.

Twenty voluntary patients were in the unit on the day of inspection. Two patients who had tried to poison themselves had been admitted from the A & E Department. The Inspectorate could not comprehend the logic of this practice, which had been a feature in this unit for some time. A day hospital service was provided in the basement of St Camillus Unit. St Vincent's Hospital also provided a later life psychiatry service which covered all of catchment areas 1 and 2. The later life service had a number of acute assessment beds in St Camillus Unit and a day hospital facility in a nearby house.

There had been no major changes to the service since the previous inspection. In the light of the proposed new developments, it was essential that a blueprint for the combined Area 2/St Vincent's Hospital service be carefully planned and the philosophy of service delivery for the entire catchment area be in accordance with government policy as set out in ''Planning for the Future''. A user group, comprising representatives of St Vincent's Hospital and the nearby community mental health team, was in place. They did not seem to have met regularly since initial discussions at the design stage of the new acute unit. More formal meetings, chaired by senior managers, were needed to ensure a smooth transition to an integrated service.

The East Coast Area Health Board and St Vincent's Hospital should consider developing a consultant-led liaison psychiatric service for the hospital, similar to the services already

developed at St James's, The Mater, Beaumont and Tallaght Hospitals. The service had no Clinical Director following the retirement of the former Professor of Psychiatry. However, this matter should be addressed with the amalgamation of the Community Mental Health Service (Area 2) and St Vincent's, Elm Park Mental Health Service.

A day hospital needed to be developed for the area and it should incorporate the new eating disorders day programme which had been developed. As the eating disorders programme was a nurse intensive activity, there was a need to plan for its continued development and to audit it annually to assess its effectiveness. The service should consider training and appointing clinical nurse specialists for this programme. A major challenge facing the existing St Camillus Unit was the shortage of nursing staff and an over-reliance on the use of agency nurses. As a result, it was difficult to ensure continuity of patient care. However, existing staff did the best they could in difficult circumstances.

There were no ECT facilities at St Vincent's Hospital and patients who required treatment were brought to Vergemount Clinic, Clonskeagh. Although the numbers were small, it was an unsatisfactory arrangement. Facilities are provided in theatre for Electro Convulsive Therapy for patients under the care of the Department of Later Life Psychiatry and patients too medically ill to be treated at Vergemount Clinic. A number of clinical files were examined. Written instructions on filing documents were required. The standard of the case notes varied. Some notes were not very legible and were difficult to follow. All entries in the medical notes should be signed in full and the designation of the professional making the entry should be clearly stated. The date of all entries was recorded. Ideally, the time of entry should also be recorded. There were no inputs from psychologists, social workers or occupational therapists in the notes examined. Apparently, each professional kept their own notes. Ideally, all clinical notes should be on one file and available to all members of the multi-disciplinary team at the discretion of the treating consultant psychiatrist. Space was provided to record a patient's name on each continuation page but this was not always done. Copies of discharge letters were readily available and contained all relevant information including follow-up arrangements and medication on discharge. Investigation reports were correctly filed. File covers were generally in good condition but there was a considerable collection of loose material in the back pockets of individual files. Risks associated with this practice included mis-filed or lost clinical data and delays in accessing pertinent information.

The 'Peplau Model' of nursing care operated in St Camillus Unit. Adequate training on the nurse care planning system was provided but it was difficult to implement effectively due to the excessive use of agency nurses. All entries in the nursing notes were dated and timed accurately and were signed in full. The patient's name was recorded on each continuation page which was satisfactory. Separate records of weekly ward and team review meetings were kept. There was a detailed local policy on the use of abbreviations. Nursing records indicated that patients were given a chance to talk about their hospitalisation. Nursing records should confirm if patients settled well into the ward at the end of their first day. Similarly, the records should reflect the involvement of patients in their own care planning, with entries about patients' wishes, preferences and suggestions relating to treatment approaches. Guidelines on the nurse care planning system were available to

staff. Appropriate training for all staff on the management of aggression and violence had commenced since the previous inspection and this was satisfactory.

A written drugs policy and procedure was in place. The legibility of individual prescriptions varied and some scripted prescriptions were difficult to read. Whilst all prescriptions were signed and dated individually, some of the signatures were illegible and this required attention. Similarly, space was provided to record the initials and full name of the nursing personnel administering prescribed medication. However, this was not completed in all forms. Space was provided to record any drug allergies to ensure information was readily available to staff. Discontinued drugs were signed off using the discontinuation column.

A number of patients were interviewed to ascertain their views on the quality of service provided. All patients were satisfied with the admission process and with the courtesy and helpfulness of staff. The patients interviewed were informed about the nature of their medical condition, including medication and treatment, and had some understanding of the explanation given about their condition. Patients were generally satisfied with the quality and quantity of food provided and with the cleanliness of toilets and bathrooms. However, they expressed dissatisfaction with the visitor facilities. All of the patients interviewed knew the name of their consultant psychiatrist and had adequate access to them whilst hospitalised. One patient sleeping near the nurses' station reported that it was not possible to get a good night's sleep as the area was sometimes noisy. Patients were not aware of their rights under the Mental Treatment Act, 1945 and amending legislation or on how to make a complaint if they felt aggrieved. When asked what should be done to improve a patient's stay in hospital, one patient replied that ''time hangs heavy'' and emphasised the need for more facilities to occupy patients other than ''television and jigsaw puzzles''. Patients reported adequate access to telephones and hot and cold drinks as required. Patients had adequate contact with the nursing staff and appreciated the nurses who made a special effort to talk to them. Patients were not aware if an individual nurse was assigned primary responsibility for their care. All patients reported general satisfaction with the care provided in St Camillus Unit.

RECOMMENDATIONS

In view of the fact that the new acute psychiatric unit is under construction, no recommendation is made in relation to in-patient care. However, it is recommended that the inadequate community-based facilities be strengthened and extended.

WICKLOW MENTAL HEALTH SERVICE — 2001 INSPECTION

INSPECTED ON 30 OCTOBER, 2001

GENERAL DESCRIPTION OF THE SERVICE

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

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

IN-PATIENT CARE

In-patient care was provided at Newcastle Hospital which provided ninety beds in three integrated units.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	7	7	3	4	21	33.33
3-12 Months	—	—	2	2	2	4	10	15.8
1-5 Years	—	—	2	1	4	2	9	14.28
> 5 Years	—	—	3	10	3	7	23	36.51
All Lengths of Stay	—	—	14	20	12	17	63	100
% of Total	—	—	22.22	31.75	19.05	26.98	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
17	20	1	7	—	—
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
1	12	—	4	1	63

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	22	22	44
Temporary	11	4	15
P.U.M.	—	—	—
Ward of Court	2	2	4
Total	35	28	63

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 598
Number of first admissions in 2000 155
Number of discharges in 2000 590
Number of deaths in 2000 7

Legal status of admissions
Voluntary 89.5%
Non-voluntary 10.5%

The number of admissions represent an admission rate of 6.6% per 1,000 of the catchment population. First admissions accounted for twenty-six per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	20	84
Day Centres	4	161	272
Out-patient clinics	9	268*	1,166

*No. of out-patient clinics held in 2000

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
4	23	4	37	1	22

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
10	11.5	72.5	39	7

COST

The cost of the Wicklow Mental Health Service was £5.6 (€7.1) million in 2000.

GENERAL COMMENTS

The Wicklow Mental Health Service comprised a network of out-patient clinics and community residences spread throughout the county with extensive facilities in Bray, Arklow and Newcastle. During 2001, facilities in Arklow had been strengthened by the purchase of a house on the Coolgraney Road which it was hoped would provide a low-support residence and facilitate the conversion of Sonas House to a high-support residence. A comprehensive sector headquarters, community mental health centre and day hospital was required for this sector to augment the existing facilities at the Lincara Centre in Bray. The service had produced a seven-year development plan which set out the steps necessary to extend the facilities already in Bray and Arklow and to provide a further sector headquarters and day hospital for the mid-Wicklow sector in Greystones. When this was completed, there would be a sector headquarters/community mental health centre/day hospital

in Bray for the North sector; Greystones for the mid-sector; and Arklow for the South sector.

In-patient care was provided at Newcastle Hospital in two units. One was a thirty-five bed acute admission unit and the other was a thirty-five bed continuing care facility. The Newcastle campus also provided non-hospital residential accommodation for approximately forty patients in three residences on the grounds. Avonmore was a high-support residence located in the former sanatorium building. Duncree was the former RMS residence which provided medium-support accommodation and Vartry House provided low-support accommodation in the former gate lodge of the hospital.

The admission rate to the Wicklow service at over six per thousand of the population was rather high. It could be explained in part by the fact that, apart from consultant elective admissions, all non-elective admissions were either self-referrals to the unit or referred by a GP, sometimes without prior notice. These patients were seen by NCHDs who usually made the admission decision. It would be preferable if these decisions were ratified by a consultant. In addition, the practice of admitting alcohol dependent patients for 'detoxification' continued. This swelled admission numbers unnecessarily and was also clinically undesirable as an admission suffering from an acute delirium tremens would be better and more safely treated in a general hospital setting. The admission unit was open and this could account for the high frequency of seclusion and special nursing. Seclusion was usually authorised by junior doctors. Seclusion episodes were well documented in the medical and nursing notes and fifteen-minute observations were also appropriately recorded. Seclusion was practised in a safe room which was in a high observation area close to the nurses' station.

The layout of the admission unit was old-fashioned but the best possible adaptation of its space had been achieved. The day area opened onto a conservatory area. Of the seven temporary patients in the unit on the day of inspection, two had had their period of detention extended but the medical case notes in one case did not record this fact. In the second case, the fact was recorded but not the reason why it was deemed necessary. This required attention. Case note design and layout was reasonable, but admission documentation, particularly in relation to a planned programme of care, was lacking in most cases. However, an assessment form for patients who presented at the unit had been introduced and this was impressive. These forms were added to the case notes if a patient was admitted and were stored in records if the patient was not admitted. There was adequate documentation on the ward for patient information and for informing patients of their rights.

The longer-stay patients in the adjoining continuing care unit, many of them highly dependent and almost half of them older persons, were well looked after. The physical surroundings in the unit had been upgraded, with a conservatory opening onto a newly opened millennium garden which allowed them free movement and access to fresh air. Some of these patients were more suited to nursing home surroundings, given that the major inputs were for physical care. The younger patients and those with functional illnesses were more suited to high-support community residences.

There was a strong case for creating at least one further consultant psychiatrist post. Consideration should then be given to designating some of the consultant posts to have a special interest in the fields of liaison psychiatry (as the Wicklow service provided a liaison service to St Colmcille's Hospital, Loughlinstown), the psychiatry of later life and rehabilitation psychiatry. This was supported by the Inspectorate. It was hoped this would lead to a greater community orientation of sector teams, particularly of senior medical staff, with the provision of community-based sector headquarters, community mental health centres and day hospitals in all three sectors. The existing day hospital at Lincara, Bray appeared to be a limited operation. The consultant attended on a sessional basis only and mainly for out-patient clinics. The Inspectorate suggested that the out-patient clinics be removed and the day hospital function be intensified and elaborated, even if this required some restructuring of the existing facility at the expense of the excellent day centre operation. It was acknowledged that there was a junior medical presence on a five-day week basis in the day hospital but the entire sector team should be more firmly based in the North Wicklow sector headquarters and operate from there. It was noted that none of the sector teams was truly multidisciplinary as no occupational therapist and only one psychologist and two social workers were employed in the service.

Uniquely among Irish counties, Wicklow did not have a general hospital and this raised problems for placing the current admission facility in a general hospital setting in line with national policy. The candidate hospital was St Colmcille's Hospital, Loughlinstown which was just over the county border and therefore not in the catchment area. However, it must be borne in mind that the great bulk of the County Wicklow population was in North and mid-Wicklow and therefore had easy access to Loughlinstown which provided an acute medical service for the population. Residential facilities in the service were of a high standard. Most of the houses were of high quality, in well-maintained grounds, well furnished and decorated and carefully looked after. They provided a very satisfactory environment for their residents, most of whom attended day facilities either in the Lincara Day Centre or the Kilmullen Enterprise Centre in the grounds of Newcastle Hospital.

As well as difficulties recruiting professionals such as social workers, occupational therapists and psychologists, there was a growing difficulty recruiting nurses. There were a number of unfilled nursing posts in the service at the time of the inspection. The Wicklow service participated in general nurse training with student nurses from Tallaght Hospital as well as psychiatric nurse trainees. The NCHD recruitment was still in the St Brendan's scheme and there were six trainee places. This service had recently been accredited for training by the Royal College of Psychiatrists. It would be preferable if Newcastle formed part of a recruitment rotation with St Vincent's Hospital, Elm Park, Vergemount and Cluain Mhuire.

There was a wide range of documentation relating to a range of issues in the service, including statistical information on characteristics of sector activity including matters such as length of stay of in-patients, admission numbers, social, demographic and medical characteristics. Similar information on out-patient activity was available. There were well-kept records on assaults, accidents and incidents within the service. The latter included matters such as deliberate self-harm by patients residing in the service, whether in the

hospital or in the community, damage to property, absconding, etc. Information on episodes of special nursing and seclusion were also available. Leaflets on a wide variety of topics, such as introductory leaflets for patients being admitted, leaflets for each individual treatment and information for relatives on coping with attempted suicide, information on schizophrenia, dementia, Alzheimer's, etc. was available. This was very satisfactory.

The very active Friends of Newcastle Hospital group comprised both personnel of the service and supportive catchment area residents. It has been active in raising considerable funds to improve the service. A major highlight in the service each year is the annual fete. The imaginative and creative use of funds has helped improve the physical resources of the service. One example was the excellent visitors' centre and multi-sensory garden at Newcastle.

Three patients were interviewed to ascertain their opinion of the services provided. They were all between twenty-five and thirty-five years of age and had previous admissions to the hospital. They all spoke highly of the service. They were well acquainted with the relevant doctors and nurses, had their illness explained to them and their treatments, including medication and side effects. They had constant access to their therapeutic team and appointments for extra consultations were easily made. They were aware of their rights under the Mental Treatment legislation and were aware of the complaints procedures. The quality and quantity of food was satisfactory and the standard of hygiene in toilets, dormitories and bedrooms was high. The patients interviewed were satisfied with the level of privacy and dignity afforded them at all times. The one complaint all three patients had was the lack of therapeutic activities, particularly recreational and occupational therapies during the day. As a result, they found the days quite boring. Access to reading material ameliorated the position somewhat. Because this complaint was shared by the three patients interviewed at random, it was of significance and efforts should be made to resolve it.

RECOMMENDATIONS

It is recommended that:—

1. A day hospital, community mental health centre and sector headquarters be provided in all three of the County Wicklow sectors where they do not exist, and be improved where they only partly exist, as in Bray.
2. A location for a general hospital-based admission unit be sought with the Board. It is suggested that suitable accommodation could be provided in St Colmcille's Hospital, Loughlinstown.
3. A fourth consultant post be created enabling it and existing consultants to take on special interests in the area of psychiatry of later life, rehabilitation psychiatry and liaison psychiatry.
4. Renewed and continuing efforts to enhance the multidisciplinary composition of existing sector teams be undertaken.
5. A greater commitment to sector activity, including domiciliary visiting in conjunction with primary care agents and community nurses, be undertaken to reduce the relatively high admission rate in the service.
6. That there be greater scrutiny by consultants of admission decisions made by NCHDs.

SOUTH-WEST AREA HEALTH BOARD

DUBLIN SOUTH CITY MENTAL HEALTH SERVICE

PSYCHIATRIC UNIT, ST JAMES'S HOSPITAL — 2001 INSPECTION

INSPECTED ON 11 DECEMBER, 2001

GENERAL DESCRIPTION OF THE SERVICE

The population of the catchment area was 90,000 and it had been sectorised in the past year into the northern Owendoher sector and the southern Camac sector.

IN-PATIENT CARE

In-patient care was provided at St James's Hospital which had a fifty-one bed unit in two integrated wards.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	21	10	7	2	40	78.43
3-12 Months	—	—	2	3	1	1	7	13.73
1-5 Years	—	—	1	2	—	—	3	5.88
> 5 Years	—	—	—	—	1	—	1	1.96
All Lengths of Stay	—	—	24	15	9	3	51	100
% of Total	—	—	47.06	29.41	17.65	5.88	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
2	20	—	13	6	—
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
2	3	1	—	4	51

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	29	11	40
Temporary	6	5	11
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	35	16	51

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 428
Number of first admissions in 2000 142
Number of discharges in 2000 431
Number of deaths in 2000 3

Legal status of admissions
Voluntary 86.9%
Non-voluntary 13.1%

The number of admissions represented an admission rate of 4.76 per 1,000 of the catchment population. First admissions accounted for thirty-three per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	50	1,900
Day Centres	1	27	150
Out-patient clinics	1	390*	Not specified

*No. of out-patient clinics held in 2000

Community Residences

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

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
12.5	—	35.5	4	8

COST

The cost of the St James's/Area 3 Mental Health Service was £4.2 (€5.3) million in 2000.

GENERAL COMMENTS

The Area 3 mental health service had made considerable progress in the past year. This was best exemplified by the appointment of an Area Manager (on a temporary basis to begin with) with responsibility for the service by the South-West Area Health Board. However, nursing in the Jonathan Swift Acute Unit and in the community services remained divided with responsibility shared between St Patrick's Hospital and St James's Hospital. The Inspectorate felt it was essential for a Director of Nursing to be appointed with responsibility for the nursing component of the service as a whole. It was felt this would create an identity of self-belief, self-direction and independence among staff members of the service. The Inspector's Report of 2000 commented on the unsatisfactory nature of the current arrangements and recommended a strengthened senior nurse management structure.

The Inspectorate had advocated the sectorisation of the service for many years and this objective had been achieved in 2001. The service now comprised the northern Owendoher sector and the southern Camac sector. A sector headquarters and comprehensive day hospital operation were to be established in each sector. St Martha's on the South Circular Road was the location for the Camac sector and a generic health centre, incorporating mental health services, was to be built on Terenure Road North for the Owendoher sector. The new day hospitals would replace the existing day hospital which was located within the Jonathan Swift acute psychiatric unit at St James's Hospital. These developments were welcomed and had convinced the Inspectorate that the Area 3 service was committed to a community-based delivery of services.

There had been renewed dialogue between the Area 4/5 service and the Area 3 service in relation to redressing the population imbalance between them. As matters stood, both were served by fifty-bed general hospital in-patient units at Tallaght Hospital for Area 4/5 and at St James's Hospital for Area 3. However, there was a huge imbalance of population between the two services with approximately 300,000 persons in Area 4/5 and 100,000 persons in Area 3. Some years ago, discussions aimed at transferring some of the Area 4/5 catchment population to the Area 3 service had been discussed but negotiations had stalled. The Inspectorate was happy to report that these negotiations had restarted.

The community residential facilities inspected were of good quality and well maintained. St Martha's premises on the South Circular Road was undergoing major refurbishment and work was expected to be completed by 17 March, 2002. The premises would then open as a sector headquarters and day hospital for the Camac sector. All community residences were situated in residential areas, blended in well with the community and were within easy access of public transport. This latter point was important as all residents attended some occupational activity during the day. Safety and fire arrangements in the residences were satisfactory.

The acute unit in St James's Hospital, also known as the Jonathan Swift Clinic, was gradually being engulfed by newer developments being undertaken on the hospital campus and it had lost its free-standing character. It was a two-storey building and embodied three components; the William Fownes Unit, a locked acute admission unit; the Beckett Unit, a sub-acute or rehabilitation unit; and the Conolly Norman Unit, a nine-bed acute assessment/treatment facility for older persons. A day hospital also operated on the ground floor. The William Fownes Unit was of poor design. It had no adequate nurse observation station so that acutely ill patients could not be directly observed. In addition, the day areas for patients were extremely limited and it was difficult to believe that such a unit, which opened just over a decade ago, could have been so badly planned. A similar lack of day space existed in the sub-acute area. However, when the day hospital moved from the ground floor area, it would be possible to reconfigure the space available to provide better and safer patient accommodation, particularly for acutely ill patients. A new nurses' station had been created just inside the locked door of the William Fownes Unit in an attempt to improve observation, particularly of persons entering and exiting the main entrance to the unit.

The unit served as an undergraduate teaching centre for medical students from Trinity College and was also approved by the Royal College of Psychiatrists for postgraduate medical training. The social work and occupational therapy schools of Trinity College had utilised the unit for training placements and this continued. There was no dedicated rehabilitation service in Area 3, but at least six patients in the sub-acute unit required community-based accommodation. In effect, the ground floor of the Beckett Ward in the Jonathan Swift Clinic functioned as a continuing-care residential centre. Clearly, this was undesirable and these beds should be used for acute purposes, particularly if the service was going to take on an enlarged catchment area. Meanwhile, a diminishing number (approximately thirty) of long-stay older Area 3 patients continued to reside in St Patrick's Hospital. The day hospital for older persons in the Area 3 service, the Martha Whiteway Day Hospital, was based at St Patrick's Hospital. According to health care delivery principles, this accommodation would be better provided from St James's Hospital.

Seclusion was not used in the Area 3 Mental Health Service and there were twenty-two episodes of special one-to-one nursing supervision involving nine patients in 2001. There were fifty-six temporary admissions during the year but none had their temporary status extended. Of the seventy accidents to patients and four accidents to staff and nine assaults on patients by other patients and four assaults on staff recorded, none were deemed serious. Fourteen patients were prescribed ECT at the Jonathan Swift Unit in 2001 and documentary procedures relating to ECT were satisfactory. Eight complaints by patients or patients' relatives were made to the local complaints/appeals manager and all appeared to have been dealt with satisfactorily.

The arrangement of the case records was somewhat confusing and haphazard and some time was required to wade through documentation relating to general hospital and surgical procedures, past the nursing notes and care plans, until one eventually arrived at the 'clinical record' i.e. the medical case notes. The quality of the medical case notes was only moderate and needed to be improved. In some instances, consultant entries were sparse and infrequent. Written instructions on filing documentation within the medical records was required. A patient's diagnosis should be recorded using a recognised classification (ICD 10). Signatures of doctors entering information in the case notes was sometimes illegible and their designation was not always recorded. Ideally, a doctor should write his/her name in capitals, sign the entry and record their designation. This would ensure easy identification of the practitioner in the future. Whilst there was provision for recording patients' names on each continuation page, this was not always done. Admission notes varied. Pathways to admission, history of presenting complaint, past history, current medication, mental state examination and physical examination on admission were well documented while notes on personal and family history were moderate. The medical filing system should be audited to identify areas for improvement in the assembly and maintenance of files and for entries into medical notes.

A written drugs policy and procedure was available for staff information and reference. It should be reviewed and updated with an appropriate review date. A number of prescription cards were examined and all were in block writing which indicated a low risk of drug error. All prescriptions were signed and dated individually and changes in prescriptions

were written as new prescriptions. Drug allergies were recorded and information was rapidly available to staff. Prescribed medication was recorded in the patient's case notes and all prescriptions were up to date. The system was generally satisfactory but the procedure for discontinuing prescribed medications was difficult to follow. While some prescribed medicines were signed off, it was difficult to know whether or not others had been discontinued.

Nursing records consisted of historical and personal data, assessment details, a nursing assessment interview, a nursing care plan and nursing notes. A new nursing care plan system had been introduced in the unit to replace the 'Roper Model' of nursing. The records examined confirmed that patients settled well into the ward at the end of their first day. Entries were made as soon as possible after the events to which they related. The records also indicated that patients were given a chance to discuss their fears about admission. All entries were accurately dated but the time of entry should also be recorded. Ideally, the records should reflect the involvement of patients in planning and making choices and decisions about their care and treatment. Entries about a patient's wishes and treatment preferences should be recorded. Nursing staff did not wear identification badges and some agency staff did not seem to be very familiar with the policies and procedures of the unit.

St James's Mental Health service had a number of policies and guidelines based on clinical administrative practice to assist staff in making decisions about clinical and administrative matters on the appropriate care of patients and the needs of staff providing that care. Policies and guidelines were available in each area for staff information and reference. The management of the service should review and update guidelines and policies in accordance with service needs. Each guideline and policy should be headed with a hospital title and individually numbered. The date of ratification and by whom should be recorded with appropriate review and audit dates. Information on patients' rights under the Mental Treatment Act, 1945 and amending legislation should be readily available for all patients in the service.

Three patients were interviewed to ascertain their views on the level of service provided. One patient had been introduced to her therapeutic team and was very satisfied with the courtesy, dignity and privacy afforded her. The nature of her illness, medications and their side effects were fully explained to her. She felt St James's Hospital was far superior to other hospitals she has previously attended. She saw her doctor frequently and, while nurses were always available, she would like them to spend more time ''talking and explaining things'' to her. She was not too happy with the hygiene levels in the toilets and bathrooms in the mornings before the cleaning staff came on duty but after their arrival the position was satisfactory.

The second patient interviewed was a temporary patient on his first admission. He had frequent consultation with his doctors and nurses and was quite satisfied with their inputs. He had not been informed of his rights under the Mental Treatment Act, 1945 and amending legislation but this information was on display in the patient areas. He did not really like the food provided but the other two patients considered it excellent. He felt the ward

atmosphere was somewhat frightening at times but he could not explain why he felt this way. He felt that facilities could be improved by providing gym facilities. The third patient interviewed had been hospitalised in the unit some months previously. She had noticed no changes to the unit since that admission. She knew her medical team well and was satisfied with the medical and nursing care she received. However, she would have appreciated more time talking with the nurses. She too felt somewhat apprehensive in the ward at times and she attributed this to the other patients being upset. All three patients mentioned that illegal drugs were occasionally used on the wards. This should be monitored. The overall impression of the service by these patients was positive.

RECOMMENDATIONS

The Inspectorate made six recommendations in the 2000 report and it was gratifying to record that four of them relating to sectorisation, the use of St Martha's premises and the provision of day hospital and sector headquarter facilities had been accomplished or were about to be put in place. The recommendations this year are therefore limited to the two outstanding:—

1. Additional community residential places be provided to release beds in Beckett Ward.
2. An independent nurse management structure be created for the Area 3 service.

DUBLIN SOUTH WEST MENTAL HEALTH SERVICE, TALLAGHT HOSPITAL PSYCHIATRIC UNIT AND ST LOMAN'S HOSPITAL — 2001 INSPECTION

INSPECTED ON 21 NOVEMBER, 2001

GENERAL DESCRIPTION OF THE SERVICE

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

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

IN-PATIENT CARE

In-patient care was provided at St Loman's Hospital where twenty-two beds were provided in one integrated ward and at the fifty-bed acute unit, the Adelaide and Meath Hospital incorporating the National Children's Hospital (AMHINCH), Tallaght.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	3	11	19	6	—	39	68.42
3-12 Months	—	—	2	3	1	—	6	10.53
1-5 Years	—	—	1	4	1	—	6	10.53
> 5 Years	—	—	3	3	—	—	6	10.52
All Lengths of Stay	—	3	17	29	8	—	57	100
% of Total	—	5.26	29.82	50.88	14.04	—	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	26	—	6	15	5
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
2	1	1	—	1	57

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	22	21	43
Temporary	7	6	13
P.U.M.	—	—	—
Ward of Court	—	1	1
Total	29	28	57

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 682
Number of first admissions in 2000 165
Number of discharges in 2000 701
Number of deaths in 2000 2

Legal status of admissions
Voluntary 89.7%
Non-voluntary 10.3%

The number of admissions represented an admission rate of 2.64 per 1,000 of the catchment population. First admission accounted for twenty-four per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	4	58	1,801
Day Centres	3	75	952
Out-patient clinics	4	499*	13,627

*No. of out-patient clinics held in 2000

Community Residences

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

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
27	28	235	69.5	13.5

COST

The cost of the Dublin South-West Mental Health Service was £13.5 (€17.1) million in 2000.

GENERAL COMMENTS

In 1997, the Eastern Health Board (now the Eastern Regional Health Authority) disposed of twenty-five acres of land on the western side of St Loman's Hospital campus which were developed for private housing. Forty-one acres remained available for redevelopment. A special care unit had been built on the campus and this was partly operational. A development control plan to ensure the orderly and phased development of the hospital campus was in place and it incorporated new hospital accommodation facilities while allowing for the phased demolition of the existing hospital units. Work on the site was envisaged in three distinct phases (Phase A — Enabling Works, Phase 1 — Redevelopment of St Loman's Hospital and Phase 2 — yet to be finalised). Following the demolition of existing structures, new access roads and other ancillary works would provide a number of facilities including a twenty-five bed psycho-social rehab centre (replacement for Unit F), a twenty-five bed extended rehab unit (replacement for St Joseph's Unit), a fifteen-bed psychiatric intensive care unit, a fifty-bed unit for older persons with mental disorders (twenty-five beds to accommodate the existing Beech Haven Unit with an additional twenty-five beds for the psychiatry of later life service) and a Central Service Unit. All of the above facilities were to be completed by 2004.

The psychiatry of later life service dealt broadly with people over sixty-five years of age who were developing psychiatric disorders for the first time or older persons suffering from dementia with behavioural or psychological problems for whom psychiatric intervention was required. However, there was a need to provide extended respite care facilities and longer-term residential care. How these services integrated with the new services being developed for older persons on the St Loman's Hospital campus was a matter for consideration.

The past year had been a year of consolidation rather than development in the Dublin South West Mental Health Service. The acute in-patient unit at the AMHINCH in Tallaght was working satisfactorily and integrating well into the general hospital. Aspen

Ward, the six-bed in-patient unit specifically designed and equipped for the department of later life psychiatry incorporated into the new acute psychiatric unit, remained closed due to staffing difficulties. A consultant in later life psychiatry and a registrar had been appointed but the service remained grossly underdeveloped due to the lack of a multidisciplinary team, the lack of access to assessment beds and a lack of alternative facilities. A strategic plan for the establishment and development of the later life psychiatry service had been published in the Eastern Health Board Action Plan for Services for Older Persons, 1999 — 2008. The construction of a day hospital on the AMHINCH campus, the identification of a suitable location for long-stay and respite care patients and the recruitment of a multidisciplinary team for the service were identified as, and remained, immediate requirements.

The department of later life psychiatry operated and reported to a separate management programme from the adult psychiatric programme. This required review. Some timeframe should be put in place to open Aspen Unit as a matter of priority. Staffing difficulties in the Eastern Region were acknowledged, but some reassessment of the skill mix and skill substitution should be undertaken within the entire service to ensure this necessary development had the opportunity to become operational. The issue of older mentally infirm persons who had grown old in the care of the mental health services was to be addressed through the provision of adequate residential facilities for this group which would replace the outdated facilities at Beechaven and St Joseph's Units on the St Loman's Hospital Campus.

A project team had been established to progress the redevelopment of the St Loman's Hospital site. The first step involved closing Unit F in the former sanatorium buildings and relocating the patients to a temporary structure on the hospital campus in order to commence demolition and rebuilding. The Inspectorate welcomed this initiative which was long overdue. The existing buildings on the site, dating back to 1948, were single storey buildings of timber stud construction with flat roofs and timber clad external walls which had deteriorated substantially giving an overall rundown appearance to the whole complex which was the headquarters of the catchment area service. The buildings were inadequate, had long outlived their usefulness, were unsuitable for healthcare use and should be replaced as soon as possible. However, the units accommodating patients were clean and some minor re-decorative work had been completed.

One liaison consultant psychiatrist post and one rehabilitation consultant psychiatrist post had received approval and they had been filled in an acting capacity pending service agreement between the area health board and AMHINCH on the split of sessions between the hospital itself and the community services. Two general adult consultant psychiatrist posts were also filled in an acting capacity. Agreement had been reached between the health board and AMHINCH on the split of sessions and it was proposed to fill all of the positions in a permanent capacity. This initiative was welcomed.

Since the previous inspection, plans to purchase a community residence in Baldonnel had been abandoned. A house at Newcastle, Co Dublin, to be used as a residential facility, had been purchased and was ready to accept residents. However, there were no immediate

plans to relocate patients to this facility due to the staffing difficulties within the service. Apparently, following a recruitment drive in Africa, a number of foreign nationals were to be employed and this should facilitate the relocation of suitably selected patients from Unit F to the new community residence. Five patients in Unit F were ready for community placement.

The Dublin South-West Mental Health Service, with a catchment area population the size of some of the smaller health boards, had access to only one clinical psychologist. This service was spread too thinly across the various sectors and no psychological service was provided to the Tallaght or Clondalkin sectors. This was a very unsatisfactory situation and should be rectified as a matter of urgency. There were forty-six nursing vacancies in the service and the service itself depended to a large extent on overtime and agency nurses. This was an unsatisfactory situation and stressful for all concerned. Serious attempts by the South Western Area Health Board were underway to address this challenge.

As mentioned in previous reports, the catchment area was too large and unwieldy. The catchment area was divided into four sectors and further sub-divided with two multidisciplinary teams operating within each sector and sharing facilities. Plans to reduce the size of the catchment area by realigning sector boundaries and reallocating a sector to the nearby Area 3 Mental Health Service (operating from the Jonathan Swift Clinic at St James's Hospital) should be pursued with the active involvement of the management of the South Western Area Health Board and the management of Area 3 and Area 4 & 5 Mental Health Services.

The management team for the service should review their five-year strategic development plan in light of securing and maximising health and social gain for people with mental illness, their carers and families within the catchment area. In tandem with this, the service management team should produce an annual report outlining the year's achievements and highlighting the strengths and weaknesses of current service provision. The development of draft policies, procedures and guidelines for the acute in-patient unit at AMHINCH was welcomed. Each of the draft policies should have a heading with the hospital title, be individually numbered, record the date of ratification and by whom it was ratified and have a review date and audit date. The service should also put in place a system to ensure a computerised index of all policies and procedures which would record dates of ratification, implementation and review. Revised or superseded policies should be removed once policies and guidelines have been ratified.

Community facilities in the Clondalkin sector, located on the Orchard Road, Clondalkin, were inspected. The facilities included a day hospital, a day centre and the base for the Home Care Team. The day hospital provided a day programme for selected patients. The facilities were rather cramped and only a small number could attend at any one time. The Home Care Team was based in the same premises as the day hospital and worked closely with the day hospital staff and the nearby day centre staff. Some research had been undertaken a number of years ago relating to the clinical effectiveness and outcomes of this community outreach service and the findings from this research should be published with a view to comparing its effectiveness with the approach in the Cavan/Monaghan service.

The programmes in the day centre were satisfactory but the overall facilities were unsatisfactory. The facilities, provided in a Scout Den, were rented by the Board at a cost of £14,000 per annum and they were run down and dilapidated. The service should relocate to an alternate premises as soon as possible.

The internal refurbishment and upgrading work at St Joseph's Unit and Beechaven Unit at St Loman's Hospital, at the day centres in Glen Abbey, Tallaght and St Columba's, Armagh Rd., at the Ballyfermot Mental Health Centre and at numerous community residences during the year was welcomed.

There were 1,268 episodes of special one-to-one nursing supervision involving forty-one patients in 2001. Whilst the number of episodes in AMHINCH had reduced by half compared to those previously recorded in St Loman's, it remained relatively high. The use of special nursing supervision should be audited every six months and should include the reason for the observation, length of time observed and any untoward incidents. Demographic data such as a patient's age, sex, principal diagnosis and legal status under the Mental Treatment Act, 1945 and amending legislation should be included in the data set. Records should also be kept of a patient's view on the progress of special supervision. A system of prescribed recorded observations should be considered as an alternative to special supervision and as a means of reducing the number of episodes of special nursing supervision.

Seclusion was not used in the acute unit at the AMHINCH in 2000 but had been used quite extensively in 2001. The seclusion rooms were stuffy, lacked adequate ventilation, had a number of blind spots and had damaged Venetian blinds. All of this, along with the colour of the walls and floors, painted a depressing picture. The seclusion rooms were not secure and two large bolts had to be fitted to the external doors. In addition, the rooms were not very clean. All of this required review by the local service providers. A seclusion register was maintained and seclusion authorisations were made by consultant psychiatrists or junior doctors (and countersigned by a consultant psychiatrist). Fifteen-minute nursing observations of patients placed in seclusion were recorded. A total of 171 accidents to patients and five accidents to staff were recorded in the service in 2000. None were deemed serious. There were 118 assaults on patients by other patients and 186 assaults on staff in 2000. Four staff assaults required further medical intervention. Sixty-seven patients were prescribed ECT during 2000. Forty-eight patients discharged themselves against medical advice and appropriate follow-up procedures were in place.

To ascertain consumer opinion on the level of service provided, three patients in the acute psychiatric unit were interviewed. The first patient had been introduced to her consultant psychiatrist and the nursing staff. She saw her consultant twice a week and her medical condition and medications had been explained to her but she was not involved in decisions regarding her care and treatment in hospital. She was a voluntary patient. She was aware of her rights under the Mental Treatment Legislation as they were framed and posted up on the walls in the patient areas. The quality and quantity of food was satisfactory and she was satisfied with the level of privacy and dignity afforded her. The bathrooms were clean and tidy and she had access to a shower whenever she wished. She found the general

ward atmosphere somewhat frightening. This appeared to be influenced by her psychiatric problems. She was keen on occupational therapy but liked the discussion groups. She was not satisfied that she had sufficient contact with the nursing staff and felt that if she didn't approach them they wouldn't approach her. She felt this was a backward step for the service because in previous admissions to psychiatric facilities she found the nurses much ''more spontaneous in their approach to patients''. ''They seem to have changed the system.'' She had never experienced anyone using illegal drugs on the wards. She had requested the services of a counsellor but her doctor considered it inappropriate at the time. When asked how she would like the services to be improved, she said that there should be greater interaction between patients and nurses and she would like a better explanation of her illness and therapies from her doctors.

The second patient had three previous admissions to other psychiatric hospitals. Generally, he felt disgruntled, felt his doctors didn't explain things in depth to him and was not too pleased with the nurses' attitude towards him. It seemed as though this disgruntlement was due to his basic underlying psychiatric condition. He was a voluntary patient but said he was not informed about his rights under Mental Treatment Legislation even though these were displayed in the patient care areas. His attention had not been drawn to these notices. He was not informed that he could seek a second psychiatric opinion although he doubted he would make such a request. He was quite critical of the standard of hygiene in the toilet areas saying they were often blocked and they lacked privacy. He was not satisfied either when making phone calls as fellow patients could overhear his conversations ''that is when the phones are working''. He felt the nurses should be more available to talk to patients and explain aspects of their illnesses and medications in greater detail. It was felt he was in the acute phase of his illness.

The third patient didn't know whether he was a voluntary or detained patient. He knew his consultant psychiatrist well from previous admissions. He maintained that the nature of his illness or the side effects of medications were never explained to him but in further conversation he showed good insight into these matters. He was quite happy with the food and its presentation and was also happy with his sleeping arrangements. He found the ward atmosphere somewhat depressing and said the only therapeutic activities he was interested in were cards and games. On the whole, his attitude to the unit was rather negative. Superficial as these patient interviews might appear, rightly or wrongly, one got the distinct impression that what used to be the bedrock of psychiatric services generally — the nurse patient relationship — was beginning to break down. It would be an enormous retrograde step were it to be true and were it to continue.

RECOMMENDATIONS

It is recommended that:—

1. Additional clinical psychologists be employed in the service.
2. The post of Consultant Rehabilitation Psychiatrist be filled in a permanent capacity.
3. The post of Consultant Liaison Psychiatrist be filled in a permanent capacity.
4. The two consultant posts in general adult psychiatry be filled in a permanent capacity.
5. Discussions commence with the nearby Area 3 Service with a view to realigning the catchment area boundaries.

6. The Aspen Ward at AMHINCH, Tallaght opens as soon as possible for department of later life psychiatry and a full multidisciplinary team be employed for this service.
7. The South-Western Area Health Board review administrative reporting relationships for the department of later life psychiatry and adult mental health services.
8. Unit F, Beech Haven and St Joseph's Wards in St Loman's Hospital be replaced as part of the local development plan.
9. The community residence at Newcastle, Co Dublin be opened and additional community residences be made available for suitable patients in Unit F.
10. Alternate and upgraded facilities be provided for day centre patients at St Killian's, Clondalkin.
11. A skill mix and skill substitution exercise to ensure optimum use of skilled nursing resources be put in place in view of the staffing difficulties experienced by the service.

KILDARE/WEST WICKLOW MENTAL HEALTH SERVICES — 2001 INSPECTION

INSPECTED ON 5 JUNE, 2001

GENERAL DESCRIPTION OF THE SERVICE

The population of the catchment area was estimated at 171,000 and it was divided into four sectors as follows:—

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

IN-PATIENT CARE

In-patient care was provided at the integrated thirty-bed Lakeview Unit at Naas General Hospital.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	2	7	4	1	—	14	33.33
3-12 Months	—	—	5	3	1	—	9	21.43
1-5 Years	—	1	14	3	1	—	19	45.24
> 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	3	26	10	3	—	42	100
% of Total	—	7.14	61.90	23.82	7.14	—	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	20	12	3	—	—
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
1	2	2	—	—	42

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	16	20	36
Temporary	1	5	6
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	17	25	42

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 617
Number of first admissions in 2000 157
Number of discharges in 2000 580
Number of deaths in 2000 2

Legal status of admissions
Voluntary 90%
Non-voluntary 10%

The number of admissions represented an admission rate of 3.3 per 1,000 of the catchment population. First admission accounted for twenty-six per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	3	30	1,084
Day Centres	3	22+Eve Holdings	22
Out-patient clinics	14	556*	10,574

*No. of out-patient clinics held in 2000

Community Residences

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

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
23	5	35	2	9

COST

The cost of the Kildare Mental Health Service was £4.2 (€5.3) million in 2000.

GENERAL COMMENTS

As mentioned in previous inspections, the use of space on the ground floor of the Lakeview Unit at Naas General Hospital needed to be examined. The provision of a designated smoking area should be given serious consideration and a visitors' area should also be considered. The clinical room at the acute unit was too small with poor quality presses and the room itself was cluttered with medical equipment, a drug trolley and an emergency trolley. The unit at the time of inspection was overcrowded and uncomfortable. Whilst no patients occupied beds on the corridor as on previous inspections and no patients were hospitalised in other hospitals, the system of lodging patients from the unit in other hospitals continued. This was unsatisfactory. The unit was operating at hundred per cent occupancy.

An acute psychiatric ward remained a key element of mental health practice. Such wards were places where dependent persons with the greatest need received care especially when they were in crises. The quality of the environment contributed to a comfortable stay but it was also an important aspect of therapy. A poor environment damaged therapy and could lead to patients discharging themselves inappropriately. The overcrowding, lack of day space on the ground floor and the locking of external ward doors all contributed to some of the problems associated with the acute unit in the Kildare service. Pressure of available beds with bed occupancy up to and at times exceeding one hundred per cent was not a satisfactory situation. Acute psychiatric care was probably the most resource-intensive intervention within the mental health service and therefore it was crucial that hospital stays were used to the best advantage, treating the patients who needed and benefited most from this regime and for the shortest time necessary.

The slow development of community-based services within the catchment area meant that hospital stays were longer than necessary. Over one-third of the patients in the unit were judged to require alternatives to in-patient hospital care. Locking the external ward doors changed the whole ethos of an acute hospital ward. A new keypad system had been installed and the ward doors were locked most of the time. A written protocol for locking external ward doors was required. As a result of the locked doors, patients were unable to access the local shop in the general hospital. In fairness to the service providers, there were considerable difficulties and challenges resulting from the considerable upheaval and rebuilding underway at Naas General Hospital.

Acute psychiatric wards were intended to provide intensive care and treatment for short-term episodes of illness and patients should therefore stay for the shortest possible time to resolve their immediate crisis and then receive on-going care in their usual place of residence or another community setting. The opening of the high-support residence at Bramble Lodge in Newbridge eased some pressure on beds in the unit but the main difficulty in the Kildare service related to the slow pace of development of other facilities. For example, the facility at Abbey View, Castledermot was ideal for use as a staffed

community residence and efforts should be made to utilise it for this purpose as soon as possible. The premises at the rear of Abbey View appeared to be structurally sound. It had been upgraded in recent years and should be used as a small day centre pending the provision of more appropriate facilities.

There appeared to be a lack of clarity in relation to the overall direction of the service. No clinical director was in position, there were no formal management meetings, meetings appeared to be ad hoc with a resultant lack of direction. A formal management structure should be in place, the management team should meet formally and appropriate minutes of meetings and decisions taken should be kept.

The renovation and restructuring of the day hospital sector headquarters at Tuas Nua in Kildare town was welcomed. Modern out-patient and day facilities had been provided within this catchment area in Celbridge and Athy in recent years and appeared to be working well. The out-patient facilities in Newbridge, which were in a rented premises, were unsatisfactory. A proper out-patient department with a small day centre attached was required at this location. One psychologist, two social workers and four occupational therapists were employed in the service. There was an eighteen-month waiting period for psychological assessment from the psychology service. This was inadequate and additional resources were required.

There had been seventy-two episodes of seclusion involving thirteen patients since 1 January, 2001. The fifteen-minute nursing observations of patients placed in seclusion were appropriately recorded. There was a seclusion register and it was noted some authorisations were made by NCHDs. Consultants should authorise seclusion. The seclusion room itself was sometimes used as an additional bed area when ward occupancy was full. As the room appeared to be purposely designed for seclusion purposes, its use as an ordinary bedroom was not satisfactory. There were 121 episodes of seclusion in 2000 involving twenty-two patients.

There were 265 spans of special one-to-one nursing supervision involving twenty-five patients in 2000 and fifteen patients were prescribed ECT. Twenty-seven patients discharged themselves against medical advice during the year. Procedures to follow up such patients were in place if deemed clinically appropriate. There were two recorded complaints/appeals made by patients or patients' relatives to the local complaints/appeals manager and all appeared to have been dealt with satisfactorily. Forty accidents to patients and six accidents to staff were recorded in 2000 and one accident required further medical intervention. There were forty-two incidents of violence on patients by other patients which did not cause any detectable injury. There were eight assaults on staff and one required further medical intervention.

A number of clinical files were examined. Written instructions on filing documentation within the medical record were clearly recorded and were available on the back cover of each file. The admission notes were generally satisfactory. Pathways to admission, history of presenting complaint, past, personal and family histories, mental state examination, physical examination, current medication and clear summary were all well documented.

Progress notes generally provided a chronological account of the illness. Whilst there was provision for recording a patient's name on each continuation page, this was not always done. Investigation reports were correctly filed, correspondence was filed in chronological order and file covers were in good condition. A considerable collection of loose clinical material was stored in the back of each patient's file. There were certain risks relating to the storage of clinical material in the back of files including misfiling, losing material and difficulty in locating pertinent information when required. Discharge letters sent to GPs contained a summary of all relevant information, follow-up arrangements, prognosis, diagnosis and medication on discharge. Copies of discharge letters were easily accessed in the clinical files.

A number of prescription cards were examined. The legibility of individual prescriptions varied. Some prescriptions used block lettering and some were scripted. Most were not difficult to read. There was a written drugs policy and procedure which was not dated. It should be reviewed and updated with an appropriate implementation and review date. Whilst all prescriptions were dated individually and signed, the prescribers should use their full signature. Discontinued drugs were not always signed off using the discontinuation column. There was an increased risk factor if discontinued prescriptions exceeded the number of current prescriptions. This was observed in a number of prescription cards examined. One card, for example, had fourteen discontinued prescriptions all discontinued by drawing a line through the prescription. The discontinuation column was not completed.

The nursing records comprised historical and personal data, assessment details and a planned intervention section with nursing notes. The 'Roper Model' of nursing was used and care plans were reviewed each week. The nursing assessment documentation examined was generally satisfactory. However, it was noted that the nursing assessment was not conducted on a readmitted patient who had been discharged six days earlier. The records examined confirmed that patients appeared to settle well into the ward at the end of their first day. All entries were dated but the time of entry should also be recorded, especially on the night reports. The system of recording 'nocte' on these reports should be discontinued. It appeared from the documentation that the goals and actions were predominantly nurse- rather than patient-oriented. Records should reflect the involvement of patients in planning and making choices and decisions about their own care and treatment. Similarly, evaluations of nursing care plans should include patients' views about their progress. Generally speaking, the nursing records were written clearly and no alterations were noted in the notes examined.

The transfer of the administration of the North Kildare nursing component of the service from the St Loman's Mental Health Service to the Kildare Mental Health Service was welcomed. This should facilitate the orderly development of services within the sector. Work was underway on upgrading Larine House in Maynooth and there were plans to extend the activity centre at Larine Court. The North Kildare sector was too large and should be sub-divided. There was no sectoral infrastructure in the Mid-East-Kildare sector, also with a large population. As a consequence, facilities at the hospital were utilised. It

was quite clear that additional high-support community residences and additional day support services were needed within the catchment area.

There was a need for better management of acute beds at every stage from admission, through the patient's stay in hospital to discharge, to ensure that all available beds were used in the most efficient and effective way. The service should designate a senior lead clinician to take on responsibility for bed management at the Lakeview Unit. Issues which needed to be addressed included alternatives to hospital care and an audit of 'revolving door patients' to try and meet their needs effectively.

A number of patients at the Lakeview Unit were interviewed to obtain their views on the level of care provided. Patients were generally satisfied with the courtesy and helpfulness of staff, knew the name of their treating consultant psychiatrist and had access to them twice weekly whilst hospitalised. Patients were informed about the nature of their medical condition, including medication, and understood what was explained to them. They were generally satisfied with the quality and quantity of food provided but were not satisfied with aspects of privacy and dignity relating to their care. They reported a lack of personal space, commented on the overcrowding, a dislike of the locked external ward doors, the lack of facilities for meeting visitors in private and the constant movement of patients between beds. Patients were not satisfied with some patients having to sleep on beds in the corridor. Male patients, in particular, commented on the lack of cleanliness in the male toilets. Female patients were satisfied with the toilets and bathrooms. All patients were able to get a good night's sleep.

Patients had adequate storage space for clothing and personal belongings and were satisfied with the facilities to wash personal clothing. When asked if there was adequate respect for privacy when being given treatment or advice, patients expressed a dislike of the nurses' station where there was no privacy. They were generally satisfied with the privacy of doctors' interview rooms. Patients reported easy access to telephone calls whilst hospitalised. One patient expressed a desire for a card phone instead of having to use coins. This should be considered. Patients were asked if illegal drugs were easily available; one patient replied 'yes', one patient replied 'heard talk of it' and other patients replied 'no'. Patients reported they had adequate access to occupational therapy or group activity whilst hospitalised and said they received information on prescribed medication and its long- and short-term effects. Two patients were not satisfied with the information provided. One patient requested information in writing but was not given it. One patient would like to get information in writing and two patients indicated that they probably wouldn't read the written information if it was given to them.

When asked what should be done to improve a patient's stay in hospital, some patients expressed a desire to spend more time talking to the nurses and indicated that there was too much emphasis on administering medicines. They felt not enough information was given to patients on daily programmes and staff appeared too busy with not enough time to talk to patients although they emphasised there were some exceptions to this. One patient replied that the staff 'are not always available at the nurses' station spending some considerable time in the nurses' office some distance away'. The Inspectorate experienced

this when returning to the unit in the afternoon when staff were in the office writing notes and the nurses' station was empty. All patients interviewed had been hospitalised previously at the Lakeview Unit. When asked if things had improved since their last admission, they expressed some improvement.

RECOMMENDATIONS

It is recommended that:—

1. A clinical director be appointed to the Kildare Mental Health service.
2. Structural developments, outstanding for some time at the Lakeview Unit in Naas General Hospital, be completed.
3. The system of lodging patients in other hospitals cease.
4. Additional community facilities in the form of sector headquarters, day hospitals and day centres be provided, particularly in those sectors lacking the necessary infrastructure. Additional community residences are required within all sectors of the catchment area.
5. Additional psychology staff be recruited to ensure an appropriate psychological service is provided with minimum waiting time.
6. Abbeyview House, Castledermot be opened as a high-support community residence.
7. The premises at the rear of Abbeyview House, Castledermot be opened as a small day service.

NORTHERN AREA HEALTH BOARD

PSYCHIATRIC UNIT, JAMES CONNOLLY MEMORIAL HOSPITAL CATCHMENT AREA 6 — 2001 INSPECTION

INSPECTED ON 27 NOVEMBER, 2001

GENERAL DESCRIPTION OF THE SERVICE

The population of the catchment area was 128,788 and it was divided into four sectors as follows:—

Sector	Population
Cabra	22,782
Finglas	43,006
Blanchardstown A	31,500
Blanchardstown B	31,500

IN-PATIENT CARE

In-patient care for the Blanchardstown sectors was provided at the twenty-two bed integrated admission unit at James Connolly Memorial Hospital (JCMH) Blanchardstown.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	11	4	1	—	16	84.21
3-12 Months	—	—	1	—	—	—	1	5.26
1-5 Years	—	—	1	—	1	—	2	10.53
> 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	—	13	4	2	—	19	100
% of Total	—	—	68.42	21.05	10.53	—	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	5	2	5	2	2
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
—	2	—	—	1	19

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	6	11	17
Temporary	2	—	2
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	8	11	19

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 250
Number of first admissions in 2000 77
Number of discharges in 2000 253
Number of deaths in 2000 1

Legal status of admissions
Voluntary 78.4%
Non-voluntary 21.6%

The number of admissions represented an admission rate of four per 1,000 of the population of the Blanchardstown sectors. First admissions accounted for twenty-one per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	10	60
Day Centres	2	60	113
Out-patient clinics	7	778*	Not provided

*No. of out-patient clinics held in 2000

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
3	34	3	24	4	67

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
20	12	59.5	22.2	7

COST

The cost of the Area 6 mental health service was £4.8 (€6.1) million in 2000.

GENERAL COMMENTS

The community services of the catchment area needed to be expanded and developed as there were serious deficits in community provision. This was particularly so in the case of the Blanchardstown sectors where there was little community development. The administrative headquarters for both Area 6 and Area 7 were on the first floor of Conolly Norman House on the North Circular Road, which also provided an out-patient service on the ground floor for the Cabra sector and for the Mater Hospital. A limited day hospital was also provided from these premises. A training and industrial centre for the catchment area existed in a purpose-built premises adjoining Conolly Norman House and its activities served a useful function. The catchment area had two day centres, one serving Cabra in a recently redecorated building of good quality at 230 North Circular Road and the second serving Finglas in an industrial estate, North Road, Finglas. The latter day centre was to move to newly acquired, better-quality accommodation in another industrial estate in Finglas in the near future. No other day facilities, day hospitals or day centres were provided in the remaining catchment area sectors.

The Inspectorate had concerns about the multiple-purpose use of Conolly Norman House and believed the services provided at this location needed to be rationalised. The day hospital programme and the type of person catered for was limited, partly because of the lack of space and partly because of a limited perception of what day hospital activity

should encompass. While acknowledging the geographical attraction of providing out-patient services from Conolly Norman House, the Inspectorate believed that combining day hospital and out-patient services within the same building, particularly when common facilities were shared between the two, was unsound. It would be preferable for out-patient activity to take place in a generic health centre. It was understood that premises in Eccles Street had been acquired by the Mater Hospital, in conjunction with the Northern Area Health Board, to provide out-patient services for the Mater psychiatric unit and its sector of Area 7. This would remove that service from Conolly Norman House. It was also understood that a generic health centre with psychiatric day hospital accommodation was to be provided in the catchment area. The Inspectorate welcomed this plan and would like to see a similar arrangement provided in the other sectors of Area 6. The news that a premises in Coolmine had been acquired to serve as a sector headquarters for the Blanchardstown sectors, replacing the current unsatisfactory building in the grounds of JCMH, was also welcomed.

As with day facilities, community residential accommodation predominated in the Cabra and Finglas sectors although the Ard na Greine high-support residence on the North Circular Road served the Blanchardstown sectors. The largest residence, St Elizabeth's Court, accommodated twenty-six patients and had been extensively redecorated and refurbished at considerable cost. This had resulted in a good quality premises for its purpose. The high-support residence at Daneswood House, Glasnevin was also of good quality and served the Finglas sector. Community residences in the two Blanchardstown sectors needed to be supplemented. The one medium-support residence was in an unsatisfactory location and had been vandalised. It was to close shortly after the inspection and the residents were to move to newly acquired premises in the centre of Blanchardstown. The service also provided a short-term residential alcohol facility, run in conjunction with the Stanhope Street Alcohol Centre, for severely dependent persons.

The later life psychiatry service covers two catchment area services, Area 6 and Area 7. It was hoped to enlarge the service by recruiting an additional consultant-led team rather than splitting the service into separate services for each of the two catchment areas as was national practice elsewhere. The service had a day hospital and a forty-bed continuing care unit in JCMH.

The acute in-patient facility for the service was Unit 9 in JCMH. The unit was unsuited to its purpose for a variety of reasons; it lacked adequate observation areas, safe rooms and other elements necessary to contain even moderately disturbed behaviour. These shortcomings had resulted in considerable difficulties for staff in the unit who reported that they had great difficulty accessing the intensive care facilities in St Brendan's Hospital for individuals who were deemed unsuitable for care and treatment in the unit. Apart from these considerations, the unit was structurally and decoratively poor with a temporary add-on structure providing bathroom facilities for the female patients.

However, a new fifty-bed acute unit was under construction in JCMH and it was envisaged that it would be commissioned and ready for occupation early in 2003. In addition to the fifty beds, a six-bed assessment sub-unit and a day hospital for older persons were being

provided. A joint working group representing the Northern Area Health Board, the Area 6 service and JCMH had been set up to delineate policy and practice in relation to the clinical and administrative management of the new unit. Nursing care in the present acute unit, and in Units 3 and 10 which also served a psychiatric function, was provided by nurses belonging to and rostered by JCMH, rather than from the psychiatric services even though the nurses themselves were trained and worked as psychiatric nurses. Unit 10 was, in effect, a unit of St Brendan's Hospital. Unit 3, on the other hand, was a forty-bed continuing care unit which was part of the later life psychiatry service for Areas 6 and 7. Unit 3 was in reasonable condition but was not ideally suited to its patient clientele.

The recruitment of two rehabilitation consultant psychiatric teams to serve the catchment area would obviously help improve some of the problems arising from the considerable number of patients in the area with long-term and seriously disabling impairments. Many of these patients would be suitable for community placement in high-level, extended rehabilitation units. One such unit was planned for the St Brendan's Hospital campus, one for the Vergemount Clinic campus and one for the St Vincent's Hospital, Fairview campus. Further relief for the service, in addition to the improved security facilities of a safe room and high observation in the new acute unit at JCMH, would be afforded by an intensive care unit on the St Brendan's Hospital campus.

Staff recruitment posed a serious problem for the progression of the services in Area 6 and involved virtually all grades of staff. There was a considerable number of nursing vacancies, not alone in St Brendan's, but also in the acute unit in JCMH where the absence of continuity of care precluded primary nursing activity. The service relied on four psychology sessions per week and the establishment of a multidisciplinary team involving psychologists proved particularly difficult because of the centralised management of psychology services in the ERHA. This had seriously hampered the provision of an appropriate and comprehensive mental health service throughout the region. Recruitment of junior hospital doctors had also proved difficult, not least because of the lack of academic visibility in this service whose rotation was allied to that of the Royal College of Surgeons (RCSI). The absence of a professorial and academic component in psychiatry in the RCSI over many years had not helped in this regard. However, the Inspectorate was informed that a new professorial appointment in psychiatry had been made by the College. It was hoped this would improve matters. The staffing difficulties, together with the absence of physical facilities, had militated against the provision of a full multidisciplinary team based in a mental health centre with accompanying day hospital in each of the service sectors. The growth of the general hospital facilities at JCMH would further increase the need for liaison and consultation services to the general hospital. This was an issue that needed to be addressed if psychiatric services of high quality were to be provided through the general hospital.

A number of clinical files were examined and the overall standard was satisfactory. Written instructions on filing documentation within the records was available. The admission notes set out pathways to admission, a history of the presenting complaint, past history, personal history, family history, current medication, mental state examination and physical examination. They were all well documented in the notes examined. A clear summary and

a clear immediate management plan were documented. Discharge letters were accessible within the file and there was a standard discharge form. Copies of the form were sent to various agencies and one copy was retained in the patient's medical folder. Some of the notes examined were difficult to follow and it was suggested that all entries in the medical notes should contain the full signature and the designation of the professional making the entry. Whilst the date was recorded on all entries, the time of entry should also be recorded. Noting the time could help reduce delays in assessment and treatment.

A new nurse care planning system had been introduced since the previous inspection. However, there were difficulties allocating a primary nurse to each in-patient due to staffing shortages and an over-reliance on agency nurses. Nursing records examined confirmed that patients settled into the ward at the end of their first day in hospital. The records appeared to identify problems that had arisen and actions taken to rectify them. Patients' names, dates of birth and addresses were appropriately recorded on all records. Evaluations of nursing care plans should include a patient's view on their progress, any negotiated changes in nursing plans and the results of such changes. Entries on nursing records were accurately dated but the time of entry was not recorded. The service should audit the nursing records in order to identify areas for improvement and staff development.

A written drugs policy and procedure was available in Unit 9 for staff information and reference. The risk factor associated with the legibility of individual prescriptions was low as all prescriptions examined were in block writing and were easy to read. There was an increased risk factor on a number of cards where discontinued prescriptions outnumbered current prescriptions. All prescriptions were dated. A system of recording drug allergies should be introduced to the prescription card when next printed to ensure information would be readily available to staff.

Seclusion was not used in Unit 9 and the service was experiencing some difficulties in managing patients who exhibited disturbed behaviour. Staff also reported difficulty in accessing beds in the special care unit, St Brendan's Hospital. The service should consider providing a safe room in Unit 9 pending the relocation of acute admission facilities to the new acute psychiatric unit. Special one-to-one nursing supervision was used in JCMH and there were 8,786 spans of special nursing in 2000. Three patients had their temporary admission orders extended during the year. There were 699 recorded accidents to patients and seventy accidents to staff in 2000 and none were deemed serious. A total of 119 patients were prescribed ECT during the year and documentary procedures relating to ECT were satisfactory.

A number of female patients were interviewed to ascertain their views on the level of care provided. All were satisfied with the courtesy and helpfulness of staff, knew the name of their consultant psychiatrist and had adequate access to them whilst hospitalised. Patients were aware of their legal status but were not aware of their rights under the Mental Treatment Act, 1945 or on how to make a complaint if they felt aggrieved. One patient reported not being informed about the nature of her medical condition, including medication and treatment. The other patients were satisfied with the information given. Patients were generally not satisfied with the quality of food provided. They reported that the food was cold and the choice was poor. One patient suggested the distance from the unit to the hospital kitchen contributed to the fact that the food was cold. Patients reported

that facilities for visitors were inadequate as they provided no privacy. One patient indicated difficulties with the toilets as they were not wheelchair accessible. In general, they were dissatisfied with the cleanliness of the toilets. One patient said ''toilets could be better'', another reported that ''there were too many patients using the toilets''.

When asked if there was adequate respect for privacy when being given advice on treatment, one patient expressed unease that other patients could hear what was being said due to inadequate facilities in the unit. Another patient expressed her discomfort talking in front of a large group of medical personnel, particularly when she had not been previously advised that a number of doctors would be present. The ward environment and ward decor, although clean, was described as run down and old-fashioned. The patients reported general satisfaction with the occupational therapy on offer, although this was some distance away from the in-patient unit. Patients requested more contact with nursing staff. Some patients felt the nursing staff were too busy and had an enormous amount of clerical work. There was a desire on the part of all patients interviewed for nursing staff to interact more with them. Patients requested a kiosk for the public phone and some system of having change available or the use of a call card should be introduced. When asked what should be done to improve a patient's stay in hospital, the patients suggested the unit should be redecorated, the choice of food should be improved, additional wheelchair accessible showers should be provided and more facilities for occupational therapy should be available. One patient suggested additional one-to-one therapy. All patients reported easy access to fresh air and claimed they were satisfied with the care they were receiving in Unit 9.

RECOMMENDATIONS

It is recommended that:—

1. Unit 10, JCMH be closed and the patients transferred to rehabilitation facilities.
2. Discussions between the Northern Area Health Board, St Brendan's Hospital and JCMH regarding the transfer of acute services from St Brendan's continue and all service members of the Area 6 catchment team be involved in these discussions.
3. Unit 9, JCMH be closed as an admission unit as soon as the new acute psychiatric unit currently under construction is ready for occupation.
4. A day hospital and other community facilities be provided in the Blanchardstown sectors as a matter of urgency.
5. The local management team review the use of Conolly Norman House with a view to some rationalisation of services provided there.
6. Access to physiotherapy and occupational therapy be provided for patients in Unit 3, JCMH.
7. Adelphi House and the two low-support residences on the North Circular Road be redecorated.
8. The patients' menu cycle and the method of food distribution at Unit 9 be reviewed and a system of recording patients' satisfaction with the overall standard of food be introduced.

ST BRENDAN'S HOSPITAL — 2001 INSPECTION

INSPECTED ON 26 NOVEMBER, 2001

GENERAL DESCRIPTION OF THE SERVICE

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

Sector	Population
Cabra	22,782
Finglas	43,006

IN-PATIENT CARE

In-patient care was provided at St Brendan's Hospital which had 183 beds in seven male and four female units of which five were continuously locked. St Brendan's Hospital provided acute residential care and assessment services for Area 6. The acute residential care was supplementary to that provided for the same catchment area by the admission unit in James Connolly Memorial Hospital. St Brendan's also provided long-term care, on historic grounds, for patients from all over the Eastern Regional Health Authority area and, furthermore, specialised intensive care services for the entire ERHA area. There was also a residential base for a specialised service for the homeless mentally ill.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	1	20	22	1	3	47	26.55
3-12 Months	—	—	20	10	4	3	37	20.91
1-5 Years	—	—	16	24	1	3	44	24.86
> 5 Years	—	—	6	31	8	4	49	27.68
All Lengths of Stay	—	1	62	87	14	13	177	100
% of Total	—	.57	35.03	49.15	7.91	7.34	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	37	12	47	—	—
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
26	32	12	1	10	177

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	60	46	106
Temporary	33	29	62
P.U.M.	—	1	1
Ward of Court	7	1	8
Total	100	77	177

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 846
Number of first admissions in 2000 255
Number of discharges in 2000 819
Number of deaths in 2000.....10

Legal status of admissions
Voluntary.....94.6%
Non-voluntary 5.4%

The number of admissions represented an admission rate of 12.9 per 1,000 of the catchment population. First admissions accounted for thirty per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

No day facilities were provided by St. Brendan's Hospital.

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
2	5	2	6	6	72

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
13.64	18.5	392	131	45.9

COST

The cost of the St Brendan's Hospital component of the service was estimated at £14.5 (€18.4) million in 2000.

GENERAL COMMENTS

For some years, the stated ambition of the former Eastern Health Board, and now the Northern Area Health Board, had been to close St Brendan's Hospital. This process had moved more slowly than first anticipated, but it was understood that the Dublin Institute of Technology was in the process of acquiring most of the seventy-five acre site and that a special committee had been set up to copperfasten this arrangement and to determine what precise acreage would remain with the Eastern Regional Health Authority (ERHA)

for the purposes of providing intensive care and extended rehabilitation services for the entire region. The Inspectorate understood that there would be three intensive care units for the region, of which one would be located on the residual St Brendan's campus, together with one of four extended rehabilitation units for the ERHA region. Service providers felt that a larger area than was originally suggested would be required. Once St Brendan's closed, personnel would transfer to mental health services in the remainder of the catchment area.

There were just over 170 patients in St Brendan's at the time of this inspection. Following a period of sharp decline over recent years, the rate of reduction had slowed in the last couple of years. The two main therapeutic care areas sustaining St Brendan's were the four intensive care units and the long-stay Wards 23 and 23A. The intensive care units functioned as short-stay wards for disturbed patients from the entire ERHA region. However, this acute population was mixed with longer-stay patients whose needs were similar to those of patients in Wards 23 and 23A for intensive and extended rehabilitation. The demand for acute intensive care derived largely from catchment area services which had inadequate admission facilities themselves such as Area 2 and Area 6 itself. In both cases, these were to be remedied in the near future through the provision of new acute psychiatric units at St Vincent's Hospital, Elm Park and James Connolly Memorial Hospital respectively. This would reduce the perceived requirement for the level of acute intensive care currently provided by St Brendan's. The issue of rehabilitating the long-stay patients in the intensive care units and Wards 23 and 23A should be addressed by providing an active and extended rehabilitation programme. A consultant rehabilitation post, backed by a comprehensive multidisciplinary team, had been approved and was to be filled shortly after the inspection. A second post was envisaged and would be welcomed by the Inspectorate, given the extent of rehabilitation required to move towards closing St Brendan's and relocating the long-stay patients to community living. A minority of patients might require accommodation in a residential ward setting.

The acute admission units in St Brendan's, Unit 3A and 3B, were unsatisfactory for acute admission purposes. They also accommodated a number of long-stay patients for whom rehabilitation and community placement were required. The units also admitted patients from catchment areas with inadequate admission facilities of their own. Overflow patients from catchment area services which should have cared for patients in their own facilities were also accommodated. These services needed to develop the facilities they required in order to keep patients within their own catchment areas.

Finally, St Brendan's admitted patients of no fixed abode, many of whom originally belonged to a parent catchment area service which had disowned them. When St Brendan's closed, a rational policy to deal with these individuals would have to be put in place, most likely by referring them back to their own catchment area services. The homeless mentally ill of Dublin city centre also constituted a substantial group of patients. The unit for the homeless, The Willows, accommodated mainly long-stay patients who required intensive and extended rehabilitation. This should be provided by the rehabilitation services to be set up in the near future. The Northern Area Health Board was committed to providing specialised outreach services for the homeless mentally ill and, in this context,

the proposed appointment of a second consultant psychiatrist and team specialising in this area of work was much needed and was anticipated.

The assessment unit in St Brendan's comprised a three-bed room (shortly to be reduced to two beds) for pre-discharge patients and a drop-in assessment centre where up to thirty or more patients could be seen in a twenty-four-hour period. Patients were self-referred, referred by GPs or came from a variety of agencies. The Inspectorate saw no purpose for the assessment unit and felt that it should be abolished as it felt that the unit attracted persons without any formal arrangements. Assessment referrals should be received formally by prior appointment at the main day facility for the Area 6 service, the community mental health centre at Connolly Norman House.

There were twelve patients in the nurses' home in what was effectively an additional ward of St Brendan's Hospital. They had moved there because conditions in their original ward were intolerable because of vermin infestation and inadequate heating and the ward had to be closed. The arrangement was temporary and they were to move back into the hospital when twelve patients in St Brendan's moved to a residence in Swords which had to be commissioned. The Inspectorate felt that the patients in the nurses' home should transfer back to St Brendan's and the twelve patients due to go to the residence in Swords should be accommodated in the nurses' home which could then be regarded as a residence.

The timeframe for closing St Brendan's and dispersing the long-stay patients to appropriate high-support residences or residential ward accommodation elsewhere remained unclear. Approximately twenty patients would move to a new intensive care unit on the St Brendan's Hospital campus, fifteen would move to the new residential facility for the homeless, fifteen to twenty would move to a purpose-built intensive or extended rehabilitation unit (formally known as the Millennium Unit), and two further groups of fifteen to twenty were to move to similar new units at Vergemount Clinic and St Vincent's Hospital, Fairview. Further high-support accommodation for the remaining long-stay patients might be required to supplement these facilities. The facilities had not yet been built and it could be that patients would be dispersed to vacant accommodation, such as that at St Ita's Hospital, if the site was sold and vacated before the new purpose-built facilities materialised.

Conditions in the admission units were unsatisfactory and, in the case of Unit 3A particularly, no adequate observation, sleeping, or non-smoking day areas existed. It was difficult to justify an attempt to adapt the units in light of the impending provision of new acute units in JCMH and St Vincent's, Elm Park. Some money was to be spent on providing curtains and rails in the male unit, as had been done in the female unit in the past year. Nevertheless, both units remained unsatisfactory for acute psychiatric treatment purposes. Conditions in Wards 23 and 23A were also unsatisfactory and the sooner alternative accommodation was found for these long-stay patients the better. A similar criticism related to the homeless unit, The Willows. Some improvements in decor and furnishings had been made in the four intensive care units but these would have to be regarded as stopgap measures. The sleeping accommodation in all four units lacked privacy and the

day areas in the male units remained unsatisfactory, with no smoke-free areas. Seclusion was frequently used in these units.

Efforts were being made to improve occupational therapy inputs by introducing occupational activities in some of the units. In this respect, the special care OT unit was providing quite a good service for the four intensive care units. On the other hand, St Brendan's service was trying to operate with a half-time psychologist and the two current social workers needed the support of additional colleagues. Attempts had been made through appropriate specialised psychiatric services to deal with personality disordered individuals by training existing staff. Nurse shortages remained a problem despite several attempts, which were ongoing, to recruit appropriate staff. Recruiting junior hospital doctors had also been a problem but had been resolved, at least temporarily.

There were 598 seclusion episodes involving eighty patients in St Brendan's Hospital during 2000. A seclusion register was maintained at all locations. There were 514 spans of special nursing supervision involving twenty-five patients during the year and fifty-nine patients had their temporary admission orders extended. The clinical notes of a patient who had an extension to their temporary admission order were examined and no written entry of a medical assessment prior to the decision to extend the order could be found. Nineteen accidents to patients and fourteen accidents to staff were recorded and four required further medical intervention. There were fifty-four recorded assaults on patients by other patients and forty-nine recorded assaults on staff by patients. Fourteen required further medical intervention. Fifty-three patients were prescribed ECT during 2000. The facilities for ECT were satisfactory. Sixty-two patients discharged themselves against medical advice. Procedures to follow up patients, if considered clinically appropriate, were in place.

A number of clinical files were examined and some of the medical notes were difficult to follow. Written instructions on filing documentation within the medical record was required. Some entries in the medical notes were unsigned and others were illegible. Ideally, the professional making the entry in the notes should write their name in block capitals, enter their signature and state their designation within the multidisciplinary team. This would ensure easier identification of the practitioner in the future. The date of all entries was clearly recorded. Ideally, the time of assessment and entry should also be recorded in the notes. The admission notes were generally satisfactory and progress notes provided a chronological account of the illness. Investigative reports and any correspondence were correctly filed. The file covers were generally in good condition but there was a considerable collection of loose clinical material in the back pocket of the files examined. With the exception of one file, copies of discharge notes were reasonably comprehensive and were readily accessible within the file.

No written drugs policy and procedure was available in the clinical areas for inspection. Individual prescription cards were not difficult to read. Whilst most prescriptions were signed and dated individually, a small number of unsigned prescriptions were noted in one unit. Space was provided to record drug allergies which ensured the information was readily available to staff. The system of discontinuing drugs by signing the discontinuation

column was, with one or two exceptions, satisfactory. An increased risk factor of drug error was noted on a number of prescription cards where discontinued prescriptions were greater in number than current prescriptions. It was recommended that these cards be rewritten. There should be a written policy for ordering, prescribing, storing and administering medicines. It should be signed and dated and be available in each clinical area for staff information and reference. The policy and procedure documentation should contain information on staff responsibilities relating to ordering drugs, supervising their storage, taking drug stocks and administering drugs, including keeping a recording of the administration, the mode of administration and the drugs given to patients on discharge. The policy should also include written criteria on the use of prescriptions.

Written safety statements were not available in a number of units inspected whilst in others the safety statement was dated 1992. It was recommended that safety statements be made available in each local area. Copies of completed hazard control sheets should be available in each local area and they should indicate periodic safety audits highlighting high, medium and low risks and actions required. Individual curtain screens should be provided in Units 3A & 3B to ensure adequate privacy for patients.

The nursing records should be audited to assess the standard of record-keeping and to identify areas for improvement and staff development. There should be a follow-through audit after one year. Intensive in-service training was required in relation to the introduction of a nurse care planning system at the hospital. Ward progress reports gave a reasonable account of a patient's progress on the ward. Entries were accurately dated, but the time of entry was not recorded and in some instances it was difficult to identify the practitioner making the entry. Ideally, all patients should be assigned a primary nurse. Nursing records should reflect the involvement of patients in planning and making decisions about their own care and treatment. Similarly, nursing evaluations should include a patient's views about their treatment progress. Entries in the nursing records should confirm if the patient settled well into the ward at the end of their first day in hospital.

Three patients were interviewed to ascertain their satisfaction with the level of service provided to them. One was temporary and two were voluntary. All had previous admissions to the mental health services. One patient said he was not introduced to his consultant psychiatrist when admitted but he knew his consultant and had had a consultation with her prior to the interview. He felt the unit lacked privacy and he thought the furnishings were dull. He indicated that the nature of his illness was explained to him and that he knew about the side effects of the medications he was prescribed. Another patient's perception of the services was very positive and she had high praise for the care the doctors and nurses had given her. She appreciated the privacy and dignity they afforded her. Over the years, she has had numerous admissions to the mental health services and she says that compared to ten years ago the services now ''were wonderful''. She described her ward as safe and cheerful and the only improvement she would wish to see was to have the blankets and sheets replaced by duvets. The third patient interviewed was a temporary male patient. Despite his involuntary detention, he was quite positive in his comments. He praised the ward ambience and the kindness of the medical and nursing staff. However, he complained about the lack of therapeutic activities during the day; he was particularly anxious that games — pool tables etc. be available to patients at all times.

RECOMMENDATIONS

It is recommended that:—

1. All the necessary steps, as set out in the report on this inspection and as set out in the five-year plan for developing appropriate alternative services to those currently provided by St Brendan's Hospital, be put in place as quickly as possible.
2. Designated smoking area and smoke-free day areas be provided in ward areas.
3. Personalised patient clothing be introduced to Unit 23.
4. Revised and updated safety statements be introduced.
5. A written drugs policy and procedure be available in all ward areas.
6. Active rehabilitation inputs be put in place for patients with enduring impairments and disabilities.
7. The assessment unit be closed and appropriate interview and assessment facilities be provided in the admission complex.

ST VINCENT'S HOSPITAL, FAIRVIEW; PSYCHIATRIC UNIT, MATER HOSPITAL; AREA 7 MENTAL HEALTH SERVICE — 2001 INSPECTION

INSPECTED ON 4 AND 18 DECEMBER, 2001

GENERAL DESCRIPTION OF THE SERVICE

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

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

IN-PATIENT CARE

In-patient care was provided at St Vincent's Hospital, Fairview where ninety-two beds were provided in five integrated units and at the fifteen-bed acute psychiatric unit, the Mater Hospital.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	1	16	18	12	2	49	53.85
3-12 Months	—	—	6	3	—	—	9	9.89
1-5 Years	—	—	1	8	4	2	15	16.48
> 5 Years	—	—	—	8	3	7	18	19.78
All Lengths of Stay	—	1	23	37	19	11	91	100
% of Total	—	1.1	25.27	40.66	20.88	12.09	100	

In-patient Population Diagnosis (31.12.00)*

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	1	3	7	—	3
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellecual Disability**	**Unspecified**	**All Diagnosis**
1	—	—	—	—	15

*This information was only provided for fifteen patients in St. Aloysius Unit in the Mater Hospital.

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	28	42	70
Temporary	9	10	19
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	37	54	89

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 952
Number of first admissions in 2000 267
Number of discharges in 2000 949
Number of deaths in 2000.....3

Legal status of admissions
Voluntary.....84.8%
Non-voluntary 15.2%

The number of admissions represented an admission rate of 6.9 per 1,000 of the catchment population. First admissions accounted for twenty-eight per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	Negotiable	1,004
Day Centres	1	—	12
Out-patient clinics	4	224	3,330

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
3	28	2	14	2	32

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
22	36.14	167	20.65	18.19

COST

The cost of the Area 7 Mental Health Service was £12.1 (€15.4) million in 2000.

GENERAL COMMENTS

The Area 7 Mental Health Service was a product of its history. It was a tripartite service run and controlled by the Northern Area Health Board in association with St Vincent's Hospital, Fairview and the Mater Hospital Psychiatric Unit. All three had an input to the service which led to a complicated administrative structure. However, it worked surprisingly well. St Vincent's Hospital, Fairview, originally a private hospital, was a stand-alone psychiatric hospital which provided an in-patient service for most of the catchment area on a contract basis. It comprised three elements: an early nineteenth-century, three-storey building; a free-standing, psychiatric admission unit erected in 1993 which provided acute in-patient care for most of the catchment area; and an acute assessment sub-unit for the later life psychiatry service for Areas 6 and 7. It would no longer provide the service for Area 6 when a similar assessment sub-unit became operational in the new acute psychiatric unit being built in James Connolly Memorial Hospital. The stand-alone acute admission unit at St Vincent's was anomalous in current planning for the mental health services which decreed that all acute psychiatric care should be provided in psychiatric units in general hospitals. The arrangement of acute in-patient care for this catchment area was neither rational nor sensible. Its development was a consequence of history and confused planning.

One sector of the catchment area provided acute psychiatric care from a fifteen-bed unit in the Mater Hospital; this was also anomalous in its small size and its limited community function. It was straining definition to refer to the Mater provision as a psychiatric unit. The unit comprised just one corridor which provided cramped and inadequate day and sleeping space with no access to external space. The limited contribution the unit could make to the catchment area was further restricted by the designation of one-third of its fifteen beds as 'liaison' beds. On the day of inspection, seven of the fifteen beds were occupied by 'liaison' patients, none of them from the catchment area. The Inspectorate felt it was an unfortunate situation that the Mater Hospital, one of the largest general hospitals in the country, did not have a psychiatric unit of sufficient size and standing to provide acute in-patient care for catchment area 7, in line with national policy.

No psychologists, social workers or occupational therapists were employed in the Mater sector. There was no sector headquarters, no day hospital and no day centre in the sector, although the team had access to the Crannóg day hospital in St Vincent's Hospital, Fairview. Once again, discontinuities existed as patients referred from the sector to the day hospital were not always followed up by the sector team. New out-patient referrals were seen in the out-patient department at the Mater Hospital but return appointments were, illogically, seen at clinics run by the Area 6 service in Conolly Norman House. The sector team did have the use of a house in Eccles Street which provided offices for consultants and others. However, it was in a poor state of repair and the basement was used as a créche for Mater Hospital staff. Attempts were being made by the sector mental health service to have this house refurbished, the office accommodation upgraded and the créche vacated so that the premises might be utilised as a sector headquarters. The Inspectorate would like to see a day hospital operation put in place to remedy the serious lack of community services in the sector.

The community services in the catchment area were severely limited and needed to be expanded. In addition, some of the existing facilities were in poor condition and badly needed to be refurbished and improved. There was only one day hospital for the entire catchment area on the St Vincent's Hospital campus. This day hospital was operated by a consultant-led medical team which catered for it exclusively. Accordingly, sector teams had no input into the treatment and management of patients they referred to the day hospital with a consequent breakdown in continuity of care. The ideal model of day hospital care provision would be for each sector to have its own day hospital and to look after its own patients. The Inspectorate appreciated that the Dublin North Central mental health service was compact and that distances within it were relatively short. Nevertheless, it was suggested that the case for an autonomous day hospital, in the Ballymun sector at least, was incontrovertible. Neither psychological nor occupational therapy services were available in the day hospital and, despite the conviction on the part of the service providers that the existence of the day hospital had greatly reduced in-patient admissions, little therapeutic activity was evident at the time of the inspection.

The community residence at 87 St. Lawrence's Road badly needed to be refurbished as the conditions were quite poor. In addition, its dual function as a day centre and medium-support residence was unsatisfactory. The two functions should be separate. The inability of the service to bring about such a separation indicated the serious lack of community facilities in the service. The day centre at 108 North Strand was also in poor condition and badly needed to be upgraded. It was understood that this leased premises was to be relinquished by the service and the centre moved to more suitable accommodation nearby.

St Louise's Admission Unit in St Vincent's Hospital was poorly designed, particularly from an observation point of view. As a result, there had been many patient transfers to the intensive care units in St Brendan's Hospital in the past and much use of seclusion and special nursing. Part of the unit was therefore partitioned off to provide an observation area. This had reduced the number of transfers to St Brendan's and the use of special nursing. However, the arrangement was not entirely satisfactory. Patients were locked in the unit during the day and, although there was access to an enclosed garden in

fine weather, patients could only leave it to go to recreational activities if a nurse was available to take them. There was also no access to a non-smoking area.

Elsewhere in St Vincent's, the mix of young and old patients, long and short-stay patients and rehabilitation and continuing care patients was not quite satisfactory. The Inspectorate felt that some rationalisation of the function of each ward needed to be undertaken. It was reported that substantial numbers of patients, including nine patients in St Louise's Admission Unit, were not in need of acute or continuing care and needed placements in community residences, nursing homes or other residential accommodation which was not available in the catchment area. Much of the accommodation, although comfortable, well maintained and clean, was old-fashioned. There was an aspiration to provide an extended rehabilitation unit in the grounds of the hospital. This would be a welcome development. With the provision of such a facility and the provision of additional residential community facilities, it should be possible to close the old building as an in-patient care facility.

Information relating to seclusion episodes, special nursing and ECT was not available from St Vincent's Hospital. A system should be put in place to track and trend all episodes of seclusion by date and time. There were sixteen episodes of seclusion involving twelve patients and twenty spans of special one-to-one nursing supervision involving seven patients in the Mater Unit in 2000. Nine patients were prescribed ECT in 2000 and documentary procedures relating to ECT were satisfactory. Twenty-seven patients in the service had their temporary admission orders extended during the year and twenty-one patients discharged themselves from hospital against medical advice. Follow-up procedures were in place if deemed clinically appropriate.

There was a good system of tracking and trending accidents and assaults within St Vincent's Hospital and reporting mechanisms were of a high standard. There were 203 recorded accidents to patients and thirty-eight recorded accidents to staff in 2000 and nine were deemed serious. Of the twenty-seven recorded assaults on patients by other patients and thirty recorded assaults on staff, four required further medical intervention. In the Mater Unit, there were fifty-one accidents to patients and two assaults on staff. None were deemed serious.

A number of medical files in both St Vincent's Hospital and the Mater Unit were examined. In St Vincent's Hospital, written instructions on filing documentation within the records was available. The final diagnosis was recorded and a recognised classification was used. The notes were legible and easy to follow and most entries were signed in full. The admission notes, which set out pathways to admission, history of presenting complaint, personal history, past history, family history, mental state examination, physical examination and clear summary and management plan, were all well documented within the notes examined. The patient's name was recorded on each continuation page. Discharge diagnosis and follow-up plans were clearly stated and discharge medication was clearly recorded. File covers were generally in good condition and inputs from psychologists, social workers, occupational therapists and other professionals were recorded and formed an integral part of the overall medical file. The service had a good quality document which set out the philosophy and principles of service delivery. The policy committee had

reviewed the service's policies, guidelines and protocols prior to the inspection to reflect the most up to date information and research available and it endeavoured to ensure that staff were fully informed in relation to clinical and administrative decision-making. The Inspectorate welcomed this initiative but felt that policy on patients' voting rights should be included in the updated policy manual. Policies, guidelines and protocols were available in each area for staff information and reference.

In the Mater Unit, written instructions on filing documentation within the medical record was required. The admission notes, which included the same type of information as those in St Vincent's, were well recorded within all of the notes examined except there was no record of the physical examination for one patient who was admitted. This had been done in the A&E Department but was not recorded in the clinical notes. The patient's name was clearly recorded on each continuation page but the signature of the doctor making entries in the clinical notes was sometimes illegible and their designation was not always recorded. Ideally, the professional making an entry in the notes should write his/her name in capitals, sign the entry and record his/her designation to ensure easy identification of the practitioner in future. Copies of discharge notes were easily accessible within the file. Discharge letters contained ICD 10 diagnosis, information on medication on discharge, a summary of all relevant information and follow-up arrangements. The file cover was generally in good condition. However, there was a considerable collection of loose clinical material in the back pocket of some files. This required attention.

The 'Roy Model' of nursing care was used by nursing staff in St Vincent's and there was appropriate training for staff on the nurse care planning system. A system of team allocation operated in the admission unit with nurses assigned responsibility for in-patients from individual sector teams. All entries in the nursing notes were accurately dated and timed. Records were written clearly and the records appeared to identify problems that had arisen and the actions taken to rectify them. The patient's name was recorded on each continuation page of the nursing record. Evaluations of nursing care plans should include the patient's views about treatment and treatment progress. The records themselves should reflect the involvement of patients in planning and making choices and decisions about their own care and treatment. In this regard, entries relating to patients' personal wishes, preferences and suggestions about treatment approaches should be recorded.

The Mater Unit used the 'Tidal Model' of nursing care and appropriate training was provided for staff. Care plans were reviewed each day or more often if necessary and each patient had an assigned primary nurse. The 'Tidal Model' ensured that the nursing records reflected the involvement of patients in planning and making decisions about their own care and treatment. The notes contained entries about patients' wishes and preferences and information on their view of their progress. All entries in the nursing notes were accurately dated, timed and signed in full. This pilot system was audited frequently to assess the standard of record-keeping and to identify areas for improvement and staff development.

The written drugs policy and procedure had recently been reviewed in St Vincent's Hospital. All individual prescriptions examined were legible which indicated a low risk of

drug error. Whilst all prescriptions were signed and dated individually, some of the signatures were illegible and this required attention. Changes in prescriptions were written as new prescriptions and information relating to drug allergies was recorded and readily available to staff. Prescribed medication was recorded in patients' case notes. A system should be put in place to easily identify the nurses administering drugs to patients. This should be done when the drug administration card is next reviewed. There was a similar policy in the Mater Unit.

Three patients in the admission unit in St Vincent's were interviewed to determine their satisfaction with the services provided. All three were acquainted with their medical and nursing teams and were satisfied with the frequency and depth of consultation with their doctors. Although the nursing staff were always available to them, they would appreciate more in-depth or longer discussions with them. None of them knew about their rights under the Mental Treatment Act, 1945 and amending legislation despite the fact that these were displayed on the walls of the unit. Nobody had drawn their attention to them. They had not been informed of how to make a complaint if they felt aggrieved either. However, they had no complaints. All were very positive in acknowledging the high standards of hygiene, décor and quality of food. Overall, they were satisfied with the services provided.

RECOMMENDATIONS

It is recommended that:—

1. Additional community facilities in the form of sector headquarters, day hospitals, day centres and residential accommodation as an alternative to inappropriate in-patient care be provided.
2. A much improved day facility be provided to replace the unsatisfactory premises at the North Strand.
3. Adequate and appropriate outdoor space be provided for patients at the Mater Hospital Unit.
4. Some of the existing community facilities which are in poor condition be refurbished.
5. The dual function of the day centre and residence on the same premises in St Laurence's Road be reviewed.
6. Patients should not smoke in the safe room at the Mater Hospital unit.
7. A designated smoking area be provided in the observation area of the admission unit in St Vincent's Hospital.
8. Consideration be given to installing a TV Camera and Monitor to cover identified blind spots in the safe room at St Vincent's Hospital. An improved observation panel should be provided on the door of the room.

DUBLIN NORTH-EAST (AREA 8) MENTAL HEALTH SERVICE

ST ITA'S HOSPITAL PORTRANE — 2001 INSPECTION

INSPECTED ON 14 NOVEMBER, 2001

GENERAL DESCRIPTION OF THE SERVICE

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

Sector	Population
Kilbarrack East	40,602
Kilbarrack West	31,946
Coolock	25,289
Killester	24,621
Dublin North County	79,699

IN-PATIENT CARE

In-patient care was provided at St Ita's Hospital, Portrane where 212 beds were provided in four male, four female and three integrated units.

Age and Length of Stay of all Patients at 31.12.00

Age **Length of Stay**	**<15**	**15-19**	**20-44**	**45-64**	**65-74**	**>75**	**All Ages**	**% of Total**
< 3 Months	—	2	30	13	2	5	52	23.53
3-12 Months	—	—	6	3	6	6	21	9.50
1-5 Years	—	—	7	9	7	12	35	15.84
> 5 Years	—	—	3	20	36	54	113	51.13
All Lengths of Stay	—	2	46	45	51	77	221	100
% of Total	—	.90	20.81	20.36	23.08	34.85	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	**Schizophrenia**	**Other Psychosis**	**Depressive Disorders**	**Mania**	**Neurosis**
24	92	36	40	7	1
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
3	8	1	5	4	221

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	90	100	190
Temporary	14	8	22
P.U.M.	—	—	—
Ward of Court	7	2	9
Total	111	110	221

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 836
Number of first admissions in 2000 252
Number of discharges in 2000 790
Number of deaths in 2000 39

Legal status of admissions
Voluntary 92.5%
Non-voluntary 7.5%

The number of admissions represented an admission rate of 4.14 per 1,000 of the catchment population. First admissions accounted for thirty per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	3	85	486
Day Centres	2	57	92
Out-patient clinics	21	1,635*	2,757

*No. of out-patient clinics held in 2000

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
1	8	5	36	1	18

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
23.5	9	246	139	3

COST

The cost of the St Ita's/Area 8 Mental Health Service was £18.2 (€23.1) million in 2000.

GENERAL COMMENTS

The five existing sectors of the Dublin North-East Mental Health Service, covering Community Care Area 8, were to be increased to six by sub-dividing the current North county sector in two, one based at Swords and the other at Balbriggan. This would reduce the

size of the existing sector of 80,000 to two sectors of approximately 40,000 each and make them more manageable. The catchment area population was already over 200,000 and was growing rapidly. This would impose administrative and health care delivery problems in the not too distant future. The community-based services were quite limited and urgently needed expansion. This was particularly true of both community residential accommodation and sector headquarters/day hospital facilities. Despite the opening of a new high-support residence at Lispopple (against considerable local opposition) and the imminent opening of another residence at Balrothery, community residential accommodation would still not reach 0.5 places per 1,000 of the population against a recommended one to 1.5 places per 1,000.

St. Francis Day Hospital was the sector headquarters for the Kilbarrack, East and West Sectors. Artane Day Care Centre was the sector headquarters for Coolock and Killester Sectors. Cúram in Swords was the sector headquarters for the North Co. Dublin Sector. A day hospital was located in Raheny (St. Francis Day Hospital) and in Coolock. In Swords and Balbriggan, a home-care outreach community service had been put in place. While the premises in Balbriggan served as a base for the home care team, it had further potential for day hospital development. The situation in Swords was more convoluted as there were two teams duplicating services and operating out of two different premises — at Castlebrook health centre in Swords which operated as a day hospital and a premises of limited size in the centre of Swords which served as a base for the home-care team. Some rationalisation was needed to unify this service and provide a more extensive day hospital premises.

Further community-based developments were underway, such as the provision of a community unit at Lusk. Community resources for the older persons in St Ita's Hospital were being sourced. A six-bed assessment unit in the new acute psychiatric unit and a day hospital for later life psychiatry at Beaumont Hospital were also planned. It was disappointing that construction of the acute unit had been further delayed. It appeared that discussion now centred on whether the unit was to be a one-storey or two-storey building. Either way, the issue should be decided as soon as possible, given the fifteen-year delay already encountered with this project. It was all the more urgent because of the unsatisfactory nature of the admission facilities in St Ita's.

There were 209 psychiatric patients in ten wards in St Ita's Hospital and in Woodview House, a designated unit in the hospital grounds, on the day of inspection. Seven of the wards accommodated older patients and sixty per cent of patients were over sixty-five years of age. There had been approximately forty deaths of older patients during 2000 and future deaths among this group of patients would decrease the number of patients further. Older people with organic damage, mainly Alzheimer's disease, were still being admitted to St Ita's for reasons that were not totally clear to the Inspectorate, some of them coming from Beaumont Hospital. Of the remaining three wards, two were for acute admissions and the third was for continuing and intensive care.

The problem of the older patients was substantial and the Inspectorate felt that much of the care provided was that for the physical disabilities of later life rather than for major

psychiatric illness. Therefore, it seemed that a comprehensive, integrated medical and social community-based service with institutional support should be established for older persons in the catchment area working in conjunction with the medical services for older persons in Beaumont Hospital. There was no reason why the existing facilities in St Ita's Hospital could not, at least in the short term, form part of this service and be de-designated. Obviously, the service would have the support of the newly-established psychiatry of later life service, both in relation to the assessment and day hospital components to be provided in Beaumont Hospital and the community outreach and continuing care components.

The admission units in St Ita's were unsuitable for modern acute psychiatric care even though they had been considerably upgraded in recent years. Once again, this highlighted the importance of constructing the acute unit in Beaumont Hospital as quickly as possible. Clinical management, particularly in terms of bed management, was unsatisfactory. As a result, patients from the acute unit were accommodated in unsuitable accommodation in other areas of St Ita's. The Willowbrook Unit seemed to serve a number of functions, including taking patients for short-term care during a period of disturbance and also catering for more enduring disability which required active rehabilitation. In this context, it was encouraging that a rehabilitation consultant, backed by a multidisciplinary team, was to take up duty in the near future.

The accommodation for older persons had been considerably ungraded in the recent past and this had improved the therapeutic environment. Nevertheless, overcrowding still occurred in the dining areas in Units L and P and this needed attention. The number of units catering for older persons would diminish when the Lusk facility opened and the infirmary ward was also to close shortly. With these closures, that area of the original St Ita's building would be vacant. It was disappointing to record once again that much of the clothing in St Ita's was from ward stock and was not personalised, although a policy of personalisation was being pursued. The poor physical conditions in St Anne's residence were a matter of concern and its refurbishment and redecoration was seen as an urgent priority. The substantial upgrading and redecoration of Woodview House in the past year was welcomed. Similar upgrading was required for Woodview Lodge.

Nursing staff were plentiful in the institutional elements of the service and, in some instances, there seemed to be over-staffing. It was felt that consideration should be given to community training and the deployment of staff to community locations once the facilities had been acquired. The appointment of later life and rehabilitation psychiatry consultants was welcomed as was the establishment of a multidisciplinary, consultant-led team in liaison with consultation psychiatry in Beaumont Hospital. Other professionals allied to medicine were scarce. While three social workers were employed in the service, there was only one psychologist and no occupational therapist.

The North-East Area Mental Health Service was co-located on the St Ita's campus with St Joseph's Intellectual Disability Service. While these services were separate and distinct for clinical purposes, the Inspectorate felt strongly that they should be administratively separate as well. The Inspectorate was not convinced that a proper managerial system

operated in the service and urged that an appropriate management team be set up, meet on a formal basis, set objectives and targets, draw up annual and five-year plans and strive to move the plans forward with appropriate speed. The same management team could review clinical documentary procedures, with particular reference to case note design and composition and initial admission patient work-ups leading to a systematic approach to care planning. Attention also needed to be given to documenting extensions of temporary patient reception orders.

There were 182 episodes of seclusion involving sixty-one patients in St Ita's Hospital Mental Health Service during 2000. Seclusion was usually authorised by junior hospital doctors. The Inspectorate would like to see greater consultant psychiatrist inputs into the authorisation of seclusion. A random check of medical notes relating to such authorisations contained inputs relating to medical assessments prior to or following seclusion episodes. Nursing notes relating to all seclusion episodes were satisfactory. The seclusion room in Willowbrook should be replaced, if necessary, with a more 'civilized' and humane room, particularly as the current room was being used for routine sleeping purposes. The Inspectorate totally disagreed with this practice. There were 398 spans of special nursing supervision involving forty-eight patients in 2000. Consideration should be given to introducing graded levels of nursing supervision and observation, although this might be difficult due to the unsatisfactory layout of the admission units. As a first step, an in-depth audit on the use of special nursing supervision and seclusion within the admission unit complex should be conducted.

Sixty-three patients were admitted on temporary detention orders in 2000 and seventeen had their temporary orders extended during the year. Forty-eight patients from the community lodged overnight in St Ita's Hospital but were not formally admitted. Sixty patients discharged themselves from the hospital against medical advice and appropriate arrangements were in place to follow up these patients. Twenty-five accidents to patients and twenty-five accidents to staff were recorded in 2000 and five required medical intervention. There were three assaults on patients by other patients and twenty-nine assaults on staff, eight of which required medical intervention. Thirty patients were prescribed ECT at the hospital during the same year. There were four recorded complaints/appeals by patients or their relatives to the local Complaints/Appeals Manager and all appeared to have been dealt with satisfactorily.

The standard of medical and nursing records within the Area 8 Mental Health Service varied. Guidance notes on the order of assembly of the medical file were printed on the back cover. It was recommended that the filing system be reviewed and updated and a system of recording drug allergies should be introduced. There was a detailed mental health assessment form in the existing file and the detail of information obtained varied. The signature of the doctor obtaining the information was sometimes illegible and their designation was not always recorded. Ideally, the doctor should write his/her name in capitals, sign the entry and record his/her designation. The date of record entries was stated but the time of assessment was not. Recording the time was useful in determining delays in assessment. Space to record a patient's name and personnel number was provided on each continuation page but this information was not always recorded. Pathways

to admission were completed satisfactorily on some files examined, but not all. One file examined showed no history of presenting complaint, the past history was not well documented and there was no record of a personal or family history. Current medication, mental state examination and physical examination were all well documented. Other files examined had comprehensive admission notes. Examination of the file of a recently discharged patient revealed that a discharge letter had issued to the patient's GP within three days of discharge; a copy of this letter was accessible within the file. The discharge letter contained diagnosis, information on medication on discharge, summary of relevant information, follow-up arrangements and prognosis.

The nursing notes examined in the admission units used the 'Orem Human Needs Model' of Nursing. Records confirmed that patients appeared to settle well into the ward at the end of their first day. All entries in the records were made as soon as possible after the events to which they related. The records appeared to identify problems that had arisen and actions taken to rectify them and the patient's name was appropriately recorded on each continuation page. Nursing records should, ideally, contain information on the patient's wishes, preferences and suggestions about treatment approaches to ensure adequate involvement of patients in making choices and decisions about their own care and treatment. Similarly, evaluations of nursing care plans should include the patient's views about their progress. Nursing records at other locations varied between some system of nurse care planning and basic nursing notes. A number of prescription cards and drug administration cards were examined. The overall standard of the prescriptions was satisfactory. They were legible and were individually signed and dated. Prescribed medication was recorded in the case notes.

Three patients were interviewed to assess their opinion on the level of service provided to them at the hospital. By and large, they were quite positive in their responses and were generally pleased with the services. Each knew the name of their consultant psychiatrist and had frequent consultations with them. The primary nurse system did not operate in the admission units but each patient knew the name of the nurse in charge and had most of their dealings with this nurse. The nurses generally were perceived as kind and helpful. The nature of the patients' illnesses and the medication prescribed and its side effects were explained to them. Two patients were quite happy with this but one would have preferred more clarity and detail. Two claimed that their rights under the Mental Treatment Act, 1945 were never explained to them while the third said they had been. All were satisfied with the standard of hygiene in the wards, the dining areas and the toilet areas and were also pleased with the privacy and dignity afforded them. One patient, who had originally been an in-patient in 1997, praised the progress that had been made since then. He was particularly pleased with the privacy and dignity now afforded patients and described all the improvements as 'wonderful'. He maintained that the quality of the nursing staff had greatly improved, as evidenced by the caring relationship they established with patients. One patient complained of the day-room being too noisy at times; he was obviously referring to loud music. He also complained at the lack of physiotherapy facilities as he felt he needed this service due to injuries sustained prior to admission. All in all, they rated the service highly.

RECOMMENDATIONS

It is recommended that:—

1. The acute psychiatric unit at Beaumont Hospital be built as soon as possible and all the necessary preliminary steps be expedited.
2. A comprehensive plan, policy and programme for the care of older persons in Area 8 involving all relevant personnel be devised. This should include the later life psychiatry service at Beaumont Hospital, the relevant community agencies, the voluntary sector, the private nursing home component and the institutional element for older persons in St Ita's, much of which would benefit from being de-designated.
3. Community-based services be extended through the provision of adequate residential community facilities throughout the catchment area to augment the existing limited facilities.
4. A sector headquarters/community mental health centre/day hospital be provided in the Kilbarrack, Artane and Coolock sectors and the traditional home care services in Swords and Balbriggan be rationalised to avoid current duplication.
5. The Woodview Lodge residence in St Ita's Hospital be refurbished and redecorated to provide an acceptable level of accommodation.
6. Nursing care plans be introduced in all long-stay wards.
7. Clothing in all of St Ita's long-stay wards be personalised.
8. Psychology and occupational therapy personnel be recruited to all sectors.

ST JOSEPH'S INTELLECTUAL DISABILITY SERVICE — 2001 INSPECTION

INSPECTED ON 8 NOVEMBER, 2001

IN-PATIENT CARE

In-patient care was provided at St Joseph's Intellectual Disability Service, Portrane where 277 beds were provided in seven male, four female and seven integrated units.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	1	3	—	—	4	1.44
3-12 Months	—	2	2	4	—	1	9	3.25
1-5 Years	—	—	11	5	3	—	19	6.86
> 5 Years	—	—	88	101	44	12	245	88.45
All Lengths of Stay	—	2	102	113	47	13	277	100
% of Total	—	.72	36.82	40.79	16.97	4.69	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	—	—	—	—	—
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
—	—	—	277	—	277

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	145	95	240
Temporary	2	2	4
P.U.M.	7	6	13
Ward of Court	10	10	20
Total	164	113	277

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 81
Number of first admissions in 2000 9
Number of discharges in 2000 74
Number of deaths in 2000 14

Legal status of admissions

Voluntary 95.1%
Non-voluntary 4.9%

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	—	—	—
Day Centres	2	18	18
Out-patient clinics	1	112*	61

*No. of out-patient clinics held in 2000

Community Residences

Low Support		Medium Support		High Support	
No. of residences	**No. of places**	**No. of residences**	**No. of places**	**No. of residences**	**No. of places**
—	—	7	45	1	8

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
5	9	274.5	224.5	1.5

COST

The cost of the St Joseph's Intellectual Disability Service was £14.8 (€18.8) million in 2000.

GENERAL COMMENTS

The intellectual disability services for the Eastern Regional Health Authority (ERHA) area were provided by a mixture of voluntary and statutory services with the contribution from the voluntary sector coming from a number of different organisations. It was difficult to view St Joseph's Intellectual Disability Service in isolation from the inputs of the voluntary organisations. These latter varied considerably, both in their geographic commitments and in the comprehensiveness or otherwise of the range of services they provided. Historically, most of the voluntary services 'cherry-picked' among the patient clientele and the St Joseph's service dealt with the more disturbed and difficult patients. The Inspectorate felt that, despite recent partnership arrangements between statutory and voluntary services, there was a long way to go before intellectually disabled persons in the ERHA area would be served by a unified, comprehensive and rationally based service with all elements working together in harmony. This co-operation would be needed for assessment, priority establishment and service delivery.

It appeared that a revision and review of the existing administrative arrangements were necessary. The Inspectorate favoured the separation of the administration for St Joseph's Intellectual Disability service from the Dublin North-East (Area 8) Mental Health Service provided in St Ita's Hospital. It was felt that the current joint administrative structure did not serve either service particularly well, but was more prejudicial to the efficiency and effectiveness of St Joseph's service. For that reason, the Inspectorate advocated an administrative structure headed by a chief executive officer with supporting staff to progress the intellectual disability service directly with the Northern Area Health Board or, preferably, directly through the ERHA. The burden of administering the intellectual disability service and the mental health service was falling upon an under-resourced administration. With an independent structure in place, the intellectual disability service could embark on a planning and management programme which it currently lacked. To highlight the deficits that existed in this area, it was only necessary to point out the disintegration of a working group which was established in 1998 to progress the intellectual disability service. The necessity of providing one-year and five-year plans for the service was apparent; such plans were not in place at present and should be the first task of an independently structured service.

A large proportion of St Joseph's Intellectual Disability service was contained in an institutional setting on the campus of St Ita's Hospital. The Inspectorate felt that with a separate administrative structure in place, much, if not all, of the institutional/residential facilities on the hospital campus could be de-designated as the majority functioned as residential rather than hospital accommodation. If some residual elements of the complex needed continuing designation because of the necessity of providing for involuntary patients, then these individual elements could be designated as 'centres' under the provisions of the Mental Health Act, 2001. Opposition to de-designation appeared to come from two sources. The first source was the nursing unions who seemed to think that

pension and promotional issues would be affected adversely by de-designation. This was not the case and management should convince all concerned of this fact. The Friends of St Joseph's, who had played such an active part in striving for improvements at St Ita's, feared that the remit of the Inspectorate of Mental Hospitals would cease to apply to de-designated facilities. While this was true, the remedy would be to seek a separate Inspectorate for intellectual disability services.

A great deal of progress had been made to improve physical conditions in areas of St Ita's occupied by St Joseph's Intellectual Disability service. For example, £1 million capital (€1,270,000) had been spent in 2000 on upgrading and re-equipping the service. The results of this were evident in the course of this inspection as the present conditions bore no resemblance to those of earlier years. Some work remained to be done, however, particularly in Dun na Rí Unit and in Rushbrook House. Recent years had seen the closure of some unsatisfactory accommodation with the transfer of patients to community residences and to Clonmethan in Oldtown, Co Dublin. A further eighteen residents were to transfer to Clonmethan. Sixty places were to be provided in two thirty-bed residences to be established in the grounds of St Ita's to complement the Oldtown initiative. This would result in further closures of in-patient hospital-type accommodation in the service.

There had been considerable improvements to the grounds of St Ita's Hospital since the inspection in 2000. They were now much cleaner and better kept, an upgraded waste disposal system had been put in place and high quality signposts had been installed. The gutters had also been cleaned and roof repairs had been carried out. However, lighting for the grounds and the external buildings needed to be improved and this should be undertaken in the near future. Likewise, there was still some work to be done on improving the roads, many of which had potholes.

There were serious deficits in the provision of appropriate clinical care for patients. The relative shortage of medical staff did not allow for individual planned programmed care approaches for each patient. This was reflected in the relative lack of medical note-taking and in the absence of team meetings to discuss the clinical status of patients at regular intervals. The total absence of social workers, psychologists, occupational therapists and physiotherapists was particularly disappointing. It was inconceivable that a service for almost 300 intellectually disabled persons should have no psychologist for clinical assessment purposes and no social worker to guide community-based services for patients and their families. Furthermore, the absence of physiotherapy for persons with physical disabilities, of whom there were many in the service, was another seriously worrying gap.

The Inspectorate remained concerned about the state of the four seclusion areas in the service. It was felt that they were most unsatisfactory and needed to be upgraded and improved. The frequency of seclusion and the paucity of clinical skills available to complement nursing inputs in dealing with disturbed patients were a matter of concern. There were 137 episodes of seclusion involving twenty-six patients in 2000 which was a marked reduction on the 296 episodes recorded in 1999. The Inspectorate had concerns about the procedures relating to seclusion. The current practice was that, in many instances, nursing staff took a proactive initiative and sought a medical person for retrospective consent and

certification on the register — most often by a junior doctor. In some cases, the imposition of seclusion and the reasons for it were not explicitly stated in the medical case notes. Similar concerns related to the use of restraint, although this practice was less frequent. A seclusion register was maintained but some of the signatures were illegible. Fifteen-minute nursing observations were maintained for all patients in seclusion. The full signature of the nurse making the observations should be recorded in the appropriate documentation.

There were 284 residents in the intellectual disability service on the day of inspection. Over sixty per cent had co-morbid psychiatric illness, thirty per cent had epilepsy and a sizeable proportion had accompanying physical disabilities. Residents were accommodated in ten hospital wards and eight community houses on the hospital campus. There were 511 spans of special nursing supervision involving six patients in 2000. Four patients were admitted on temporary admission orders and three patients had their temporary orders extended during the year. There were 115 recorded accidents to patients and thirty-four recorded accidents to staff and five of the accidents to patients required further medical intervention. Ninety-two assaults on patients by other patients and seventy-four assaults on staff were recorded; four staff assaults and four patient assaults required further medical intervention. A system of tracking and trending accidents and assaults by time of occurrence and location needed to be put in place.

The Inspectorate noted the active involvement and participation of the Parents and Friends of St Joseph's, which included formal visits to the service, meetings with management representatives and visits to clinical locations. Copies of the group's reports were forwarded to the Inspectorate. In addition to talking to individual patients at various clinical locations, the Inspectorate met the chairman of the Patients' Committee, a resident of Fern Lodge. She appreciated the developments within the hospital but requested that improved lighting and repair of potholes on the road approaching Fern Lodge be provided; the Inspectorate supported this request. The safety statement for the hospital and local units was dated 1992 and it needed to be reviewed and updated.

Previous reports have referred to difficulties recruiting psychologists, physiotherapists, etc. to the St Joseph's service. This difficulty also involved nursing staff and, on the day of inspection, there were fifty-five unfilled nursing vacancies. This was felt to have a negative effect on service provision and development. On the other hand, one had the impression that some areas of the service were over-staffed and that a more judicious deployment of existing staff would be of benefit.

RECOMMENDATIONS

It is recommended that:—

1. An independent administrative structure for the St Joseph's Intellectual Disability Service, independent of St Ita's Mental Health Service, be established. Appropriate senior managerial personnel should report directly to the ERHA.
2. The independent administrative structure for St Joseph's Intellectual Disability Service should be an integral part of the intellectual disability service for the ERHA

region and should establish a solid, mutually responsible and communicative relationship with the voluntary agencies providing services in the same region.

3. Most of the existing residential wards in the St Joseph's service be de-designated.
4. Renewed efforts be made to recruit professional personnel at all levels to provide a true multidisciplinary service.
5. Community-based residential facilities be extended at Oldtown and elsewhere in the catchment area, including the two projected houses for St Ita's Hospital campus.
6. Dun na Rí Unit and Rushbrook House be upgraded and refurbished.
7. A rehabilitation unit for female patients with challenging behaviour be put in place.
8. The seclusion rooms be upgraded.
9. The buildings in the courtyard area be inspected by maintenance engineers to assess their safety.

CHAPTER THREE

Midland Health Board

LAOIS/OFFALY MENTAL HEALTH SERVICE — 2001 INSPECTION

INSPECTED ON 23 MAY, 2001

GENERAL DESCRIPTION OF THE SERVICE

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

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

IN-PATIENT CARE

In-patient care was provided at St Fintan's Hospital, Portlaoise where 104 beds were provided in one male and three integrated wards.

Age and Length of Stay of all Patients at 31.12.00

Age **Length of Stay**	**<15**	**15-19**	**20-44**	**45-64**	**65-74**	**>75**	**All Ages**	**% of Total**
< 3 Months	—	4	20	7	4	1	36	37.11
3-12 Months	—	—	1	5	1	2	9	9.28
1-5 Years	—	—	2	10	1	5	18	18.56
> 5 Years	—	—	6	12	6	10	34	35.05
All Lengths of Stay	—	4	29	34	12	18	97	100
% of Total	—	4.12	29.90	35.05	12.37	18.56	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	**Schizophrenia**	**Other Psychosis**	**Depressive Disorders**	**Mania**	**Neurosis**
3	44	2	25	3	1
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
3	9	3	4	—	97

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	65	24	89
Temporary	2	5	7
P.U.M.	—	—	—
Ward of Court	1	—	1
Total	68	29	97

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 736
Number of first admissions in 2000 191
Number of discharges in 2000 728
Number of deaths in 2000 2

Legal status of admissions
Voluntary 96.3%
Non-voluntary 3.7%

The number of admissions represented an admission rate of 6.6 per 1,000 of the catchment population. First admissions accounted for twenty-six per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	3	26	241
Day Centres	4	57	131
Out-patient clinics	11	381*	1,228

*No. of out-patient clinics held in 2000

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
13	66	2	13	2	32

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
11	16	119.82	82.82	14.5

COST

The cost of the Laois/Offaly Mental Health service was £9.2 (€11.7) million in 2000.

GENERAL COMMENTS

The Laois/Offaly Mental Health Service had three community-based sectors with sector headquarters, community mental health centres and day hospitals in Portlaoise, Birr and Tullamore. It was hoped to improve facilities in Birr by moving from the existing convent

premises to more spacious accommodation. Efforts had been made to differentiate day hospital services from day centre services and the Triogue Centre, Bridge Street in Portlaoise was now exclusively a day hospital and day centre patients attended the activation unit in St Fintan's Hospital. The recruitment of social worker, occupational therapy and psychology personnel for the multidisciplinary teams had progressed, though further appointments were required to ensure true multidisciplinary teams were in place. The psychiatry of later life team was truly multidisciplinary and a child psychiatric service working from a premises in the general hospital was well-established.

The acute psychiatric unit at Portlaoise General Hospital was under construction and, when completed, it was proposed that it be used to care for medical patients for a period of approximately four months while structural changes and additions were being carried out in the general hospital medical wards. The Inspectorate feared that this could jeopardise occupancy of the new unit which was required because of the unsatisfactory admission accommodation in St Fintan's. The admission accommodation had been separated into male and female wards since the previous inspection and the provision of separate facilities for male and female patients was an improvement. Nevertheless, the accommodation was still unsatisfactory. It did not allow for satisfactory assessment procedures of patients who came to the unit with no prior screening or assessment. This led to unnecessary and inappropriate admissions. It was felt that the move to the new acute unit in the general hospital was essential and should take place as soon as possible.

There was a lack of community residential accommodation for patients in the rehabilitation unit in St Fintan's and, as a result, some patients were blocking beds. It was felt that a specialist rehabilitation service should be put in place. A considerable amount of money has been spent upgrading aspects of St Fintan's, in particular the rehabilitation unit, but this was not an indication of any enduring commitment to St Fintan's but an attempt to improve basic conditions for the remaining residents in the short term. New developments in Tullamore by the recruitment of a liaison nurse in the area of suicide prevention were welcomed as were other initiatives undertaken by the board in this particular field.

There was considerable anxiety among staff on the implications for the psychiatric service with the enlargement of Portlaoise prison to accommodate up to 750 prisoners. The psychiatric needs of the prison population clearly required attention and it was the Inspectorate's view that this would be best met by an extension of the National Forensic Psychiatric Service with in-house provision at the prison itself rather than involvement by the Laois/Offaly Mental Health Service. It would be most undesirable to overburden the service in the absence of more appropriate responses for the psychiatric problems arising among such a large group of prisoners.

A comprehensive review of existing nursing practices was conducted by the relevant professional staff following the increasing use of nursing overtime at St Fintan's Hospital and an action plan was put in place to address the issues raised. A new nursing observation policy document was introduced in the service on 1 February, 2001. A high observation area was provided in the admission units as an alternative to the increasing use of special

one-to-one nursing supervision. This area was set aside for a small group of patients who required high levels of monitoring and supervision. While the observation area had not eliminated the need for special supervision, it offered the potential to reduce its use considerably by providing increased choice and more flexibility to the professional staff when tailoring care plans to suit individual patient needs. Special policies and procedures were put in place for special one-to-one nursing supervision. There were 1,158 spans of special nursing supervision involving twenty-one patients in St Fintan's Hospital in 2000.

The service management team met each month and appropriate minutes of the meetings were kept. Health and safety statements were available at each location and these were being updated at the time of inspection. Safety meetings were held each quarter. The fire alarm system within the hospital had been upgraded and regular fire drills were carried out. Records of all fire exercises were kept. A new training officer was appointed to the service with a view to the development of educational programmes for specialist and advanced practice. Educational initiatives at St Fintan's resulted in increased participation in in-service education programmes. In-service training courses included manual handling and safe lifting of loads, CPR and FBAO management. The library and resource facilities at St Fintan's had also been improved. A regional project team charged with the development of a records management policy had commenced work since the previous inspection.

There were nineteen episodes of seclusion involving three patients in St Fintan's in 2000. An appropriate seclusion register was maintained and seclusion authorisations were made by a consultant psychiatrist. Fifteen-minute nursing observations of patients placed in seclusion were appropriately recorded. Eighteen patients were prescribed ECT during 2000 and a new written ECT protocol had been produced since the previous inspection. In addition, new equipment had been provided in the ECT treatment room. Forty-four patients discharged themselves from St Fintan's against medical advice. The service had a policy for dealing with patients taking discharge against medical advice which included follow-up arrangements if appropriate.

Five recorded complaints/appeals by patients and relatives of patients were made to the local complaints/appeals manager. In addition, seven Freedom of Information requests were made during the year and they all appeared to have been dealt with satisfactorily. Twelve accidents to patients and seventeen accidents to staff and one assault on a patient by another patient and eight assaults on staff were recorded during 2000. Three of the accidents and four of the staff assaults required further medical intervention. Safety procedures were under review at the time of inspection. The policy procedure relating to accidents/incidents and assaults should be extended to include an analysis by time of day and night, geographical location, cause of accident/incident and nature of any injury.

A number of medical records in the admission area were examined and they were satisfactory. Pathways to admission, history of presenting complaint, past history, personal history and family history were all well documented. The mental state examination of patients was well documented as was current medication and record of physical examination. There was a clear summary with an immediate management plan. The patient's name was recorded on each continuation page. Progress notes provided a chronological account of

the illness and inputs from paramedical professionals were recorded in the notes. File covers were in good condition. In some large files, it was difficult to locate some details due to haphazard filing. For example, some investigation reports were stored in the back pockets of larger files and there was a considerable amount of loose clinical material in the back of some files. Instructions on filing documentation in the medical records should be provided. Dates of entry on the records were clearly recorded but the time of entry was not. Recording the time was useful in determining any delays in assessment or treatment. A discharge note was sent to the patient's GP on the day of discharge. Copies of discharge letters were examined and were satisfactory. The letters contained information on medication on discharge, a summary of relevant information, follow-up arrangements, prognosis and diagnosis. Copies of discharge letters were easily accessed within the files. Some medical signatures were illegible and this required attention.

Prescription cards were also examined. A written drugs procedure and policy was available for staff information and reference. Most of the prescriptions were in block letters and were easy to read. However, a small number of scripted prescriptions were difficult to read. There was a moderate risk factor associated with difficult to read scripted prescriptions. All prescriptions were signed and dated individually and changes in prescriptions were written as new prescriptions. Drug allergies were recorded and the information was readily available to staff. Prescribed medications were clearly recorded in patients' case notes. All prescription cards were kept up-to-date and a new nurse recording system provided for recording the full signature of the nurse administering drugs to patients. This was satisfactory. The service should consider providing written information to patients about their medication.

Nursing care plans using the 'Roper model' of nursing were used in the service. Care plans were reviewed each day in the admission unit and each week in the rehabilitation unit. Patients' names were appropriately recorded on each continuation page of the care plans. The nursing records identified problems that had arisen and actions taken to rectify them. Records were written clearly, dated accurately and no abbreviations were noted in the records examined. The service should ensure that records could be read when photocopied. The time of entry should be recorded and the nurse should use their full signature with blocked lettering alongside the first signature. There were problems and risk factors associated with loose pages within the nursing records, particularly in Ward 6. A greater correlation between the nursing interventions and nursing notes was also required. It was suggested that the nursing records be audited to assess the standard of record-keeping and to identify areas for improvement and staff development. In particular, the records should reflect the involvement of patients in planning and making choices and decisions about their own care and treatment.

A number of patients were interviewed to ascertain their views on the level of service provided and to highlight areas where the local service may need to make changes to respond to patients' wishes. All of the patients interviewed were satisfied with the courtesy and helpfulness of staff and with the admissions process. They had easy access to the service when required and all patients except one knew the name of their consultant psychiatrist and had adequate access to them. They were informed of the nature of their

medical condition, including medication and treatment. The patients interviewed generally understood what was explained to them regarding their illness and were aware of their legal status in hospital. However, two patients were unaware of their rights under the Mental Treatment Act, 1945 or on how to make a complaint if they felt aggrieved. The remainder were aware of their rights and had read the notices prominently displayed in the clinical areas of the hospital. All were satisfied with the quality and quantity of food provided.

By and large, patients were satisfied with the sleeping arrangements and were able to sleep well. One was dissatisfied with the visiting arrangements, reporting no privacy and the need for a separate visitors' room in the admission area. The majority of those interviewed felt the toilets and bathrooms could be cleaner but they did have adequate access to a bath or shower within a reasonable time of asking. One female patient said there was only one bathroom in the admission area and another reported no hot water before 8 a.m. and after 6 p.m. This was due to essential maintenance work being carried out at the time of the inspection which affected the quantity of hot water available. The female patients requested the installation of a shower unit in the female ward. Most patients had adequate storage space for clothing and personal possessions. While facilities to wash patients' clothing were available, some patients complained that the clothes dryer had not been working for the week prior to the inspection. Patients felt the environment in the admission unit was average. It was clean and tidy but some redecoration was required.

One patient complained about the personal hygiene of some patients and another found the days long and boring. Other patients welcomed access to the new activities centre and found reporting activities at the centre helpful. The patients interviewed felt that contact with the nursing staff was satisfactory and most knew the name of their primary nurse. Those in the male unit had access to mobile phones stored in their lockers but mobile phones were not allowed in the female unit. The female patients complained that the public phone had been out of order but they were allowed one telephone call a day from the ward office. When asked what patients think should be done to improve their stay in hospital, some patients suggested improving the decor, others requested more activities and some patients said they found the multidisciplinary team meetings daunting, particularly waiting in the day room to be called. One female patient suggested more interaction with nursing staff who always seemed to be doing paperwork in the office. One patient suggested the staff should be more engaged in highlighting the stigma associated with mental illness. She suggested more emphasis should be placed on out-patient care as in-patient care within psychiatric hospitals remained a stigma and neighbours did not visit patients.

All patients had adequate access to hot and cold drinks and unrestricted access to the outdoors and all reported general satisfaction with the care they received at St Fintan's and they had an active involvement in decisions affecting their care. They were given information about their medication and were satisfied with the information provided. Some would like written information on prescribed medication. All patients interviewed had been previously hospitalised in St Fintan's and, when asked if things had improved since their last admission, they reported improved and more relaxed facilities.

RECOMMENDATIONS

It is recommended that:—

1. The acute psychiatric unit, Portlaoise General Hospital be made available to the service as soon as possible.
2. The National Forensic Psychiatric Service be extended and enlarged through the provision of a comprehensive service to prisoners with psychiatric illness in Portlaoise Prison.
3. A multidisciplinary rehabilitation team be set up to deal with the residual long-stay population at St Fintan's Hospital to ensure their community placement and to bring rehabilitative psychiatric skills to those patients in need of it in community care and other settings in the Laois/Offaly service.

LONGFORD/WESTMEATH MENTAL HEALTH SERVICE — 2001 INSPECTION

INSPECTED ON 20 JUNE, 2001

GENERAL DESCRIPTION OF THE SERVICE

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

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

IN-PATIENT CARE

In-patient care was provided at St Loman's Hospital, Mullingar where 184 beds were provided in four male and three female wards.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	1	17	18	5	2	43	23.37
3-12 Months	—	—	8	5	2	3	18	9.78
1-5 Years	—	—	7	9	12	10	38	20.65
> 5 Years	—	—	10	27	26	22	85	46.20
All Lengths of Stay	—	1	42	59	45	37	184	100
% of Total	—	.54	22.83	32.07	24.46	20.10	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
9	101	3	20	18	6
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
7	11	1	7	1	184

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	82	60	142
Temporary	18	8	26
P.U.M.	4	4	8
Ward of Court	6	2	8
Total	110	74	184

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 807
Number of first admissions in 2000 178
Number of discharges in 2000 791
Number of deaths in 2000 19

Legal status of admissions
Voluntary 85.7%
Non-voluntary 14.3%

The number of admissions represented an admission rate of 8.5 per 1,000 of the catchment population. First admissions accounted for twenty-two per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	3	Non-specific	320
Day Centres	4	Non-specific	161
Out-patient clinics	5	325*	1,317

*No. of out-patient clinics held in 2000

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
8	34	3	26	3	38

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
9	15.8	190.5	100.5	8.7

COST

The cost of the Longford/Westmeath Mental Health Service was £10.8m (€13.7m) in 2000.

GENERAL COMMENTS

There were a number of concerns with the Longford/Westmeath Mental Health Service. In relation to the community services, the former convent premises in Edgeworthstown which had great potential to provide high-support residential facilities and a vastly

improved quality of life for patients from St Loman's Hospital had passed from the Mental Health Services to the Intellectual Disability Services. It was tragic that such an opportunity for the service was lost as a result of failure to secure agreement in relation to union issues. Other reasons as to why the building was lost to mental health were provided but they were unconvincing. The Inspectorate recommended that the medical components of the sector teams, in particular, should base themselves at and work out of the mental health centres in Athlone, Longford and Mullingar as medical staff only seemed to attend twice a week to see day hospital attendees and to run out-patient clinics at these locations.

Considerable difficulties with the Longford Community Mental Health Centre/Day Hospital were noted. The use of the premises as a combined day centre/day hospital operation was unsatisfactory and this was acknowledged by local service providers. Historically, the day centre operation was separate and operated in a different premises but the patients no longer attended this separate premises. The day hospital operation was thus weakened and the day centre activity was not helped either. In addition, the design of the mental health centre was not satisfactory for day hospital purposes. Apart from one large room (now occupied by day centre patients) and the dining area, there was no space large enough to accommodate even moderately ill patients with psychotic disorders. The day hospital function was limited to the ''worried well'' and made no provision for more seriously ill patients. A number of other sessional activities further diluted hospital space. The matter was further compounded by out-patient clinics which formerly were held at Longford General Hospital Out-patient Department. But they had been transferred misguidedly to the day hospital premises. On a more positive note, sector community nurses and a full-time social worker and psychotherapist worked full-time from the mental health centre. Overall, the premises were inadequate and seriously limited the amount of community-based activity that could be carried out. However, a major development plan for the St Joseph's Hospital site was being put in place and the planning team included a psychiatric representative. Apparently, provision was to be made in the planning process for a sector headquarters and a community mental health centre which would include the day hospital for the Athlone sector.

All of the Longford community residences were inspected. The Hillcrest residence was severely damaged by fire a number of months ago. The residents responded appropriately and the fire brigade was on the scene within minutes. Ironically, the residents were being accommodated in Edgeworthstown when Hillcrest was being renovated. The inspection of a semi-detached local authority residence in Spring Lawns was distressing as the house was in an unsatisfactory condition and required immediate attention. The house was in a poor state of decorative repair; the front garden was overgrown, the back garden had weeds three feet high, the windows had not been painted for some time, caravans were parked in front of and to the side of the house, the front door was splattered with the remnants of eggs and eggshells which were thrown at the premises by youngsters in the area and a pane of glass in the front door was broken. One of the residents said this was a common occurrence and that the house was under constant harassment from neighbours. The gardaí had been informed but the nuisance continued. Internally, the battery-operated fire alarms did not work and one single bedroom had no floor coverings.

A multidisciplinary, consultant-led later-life psychiatry team was to be put in place later in the year. No separate patient assessment facilities would be made available but some beds in both the male and female admission wards would be allocated to the team. The ground floor in St Brigid's block behind the main hospital was being redecorated for use as a temporary day hospital for the later life psychiatry service pending the provision of a permanent structure on the grounds of Mullingar General Hospital. The occupational and activation centre for the patients in St Brigid's block had been transferred to the nurse's home. It was hoped to de-designate St Brigid's block in the not too distant future as a continuing care unit for older patients. This would be a welcome development.

While the Longford/Westmeath Mental Health Service did have a child and adolescent psychiatric team, there was no designated in-patient unit in the Board's area. As a result, two children under sixteen years of age were admitted to St Loman's Hospital during the past year and were cared for by the child psychiatric team whilst in-patients. The Board planned to eventually have three child and adolescent psychiatric teams servicing the entire Midland Health Board area. Many of the staff the Inspectorate met with in St Loman's felt that a large number of patients in the hospital could be resettled in the community if the appropriate rehabilitation inputs were available. This was why a specialised rehabilitation team was essential to progress the service and reduce the number of institutionalised patients. All of this made the loss of the Edgeworthstown premises disappointing.

The admission rate of 8.5 per 1,000 of the catchment population was very high. This was hardly surprising as there appeared to be no admission policy operating in the hospital even though one was formulated as far back as 1985. Patients presented themselves or were referred from community sources indiscriminately to the unit and almost invariably seemed to be admitted by a junior doctor. As a consequence, the twenty-five male and twenty-five female admission beds were regularly exceeded and extra beds had to be erected in the wards to augment the more than adequate number already available. As a result, patients were regularly admitted or transferred to other wards in the hospital. This was unsatisfactory.

On the day of inspection, renovation work on the female admission unit was still proceeding. This work had been in progress for two years. As a consequence, the female admission ward was still located in temporary premises in the old St Loman's Hospital building in conditions which were unsatisfactory for admission purposes. Male patients remained in the unsatisfactory accommodation in the other half of the existing admission unit and would transfer to the renovated area of the admissions block when renovation work was completed. At the current rate of progress, this would probably be a minimum of three years. In this time span, it was expected that a new acute unit should be available in Mullingar General Hospital as it had been included in Phase 2B of the capital project at that hospital. The expenditure of millions of pounds on the current admission unit in St Loman's therefore made it essential that, when it was finally ready and vacated, it should be used for other purposes in the Board's overall plan, possibly in relation to care services for older persons.

No occupational or recreational facilities were available for either admission patients or longer stay patients in St Anne's and St Edna's Wards, despite the recent competitions to employ occupational therapists. ECT was not administered in St Loman's Hospital and patients who required ECT were transported to Longford/Westmeath General Hospital for treatment. As well as raising patients' anxiety, this also required nursing staff to accompany the patients with at least two nurses missing from the wards on days when patients were given ECT. Eighteen patients were prescribed ECT in 2000 and the ECT consent form was satisfactory.

Documentation in many of the medical case notes left much to be desired. Given that the service had recently been recognised for postgraduate psychiatric training purposes, the quality of admission note-taking by junior doctors was disappointing. From the case notes inspected it appeared that patients were not the subject of a planned care programme approach on admission. All of the documentation inspected was poor and, in one instance, a patient had two entries in the case notes on the day of their admission and no further medical notes until the patient was discharged four weeks later. Entries were usually initialled and it was not possible to decipher who was responsible for the entry in some cases. The prescription sheets used allowed for initials only and precluded the entry of a full signature thereby making it impossible to identify who had prescribed drugs.

On the positive side, there had been some improvement in the furnishings and decor in the wards in St Loman's Hospital. The improvements in St Edna's ward were impressive, even though it was still felt that the ward should close and the patients dispersed elsewhere. The four patients from the Laois/Offaly Mental Health Service should return to that service. However, the improvements in the furnishings and decor had resulted in a new spirit pervading the ward with much less disturbance and a great reduction in the number of episodes of seclusion. There had been no seclusion in the ward to date in 2001.

The increase in social workers, psychologists and occupational therapists in the service was welcomed. The service now employed seven NCHDs. This was to be augmented by an additional two NCHDs, including one for the later life psychiatry service. It was also hoped to employ some GP trainees as NCHDs in the near future.

A development and control plan was being drawn up for St Loman's Hospital campus and it seemed likely that a number of services, other than psychiatry, would be accommodated on the site. The mental health services expected that the plans would include a fourteen-bed intensive care unit for the disturbed mentally ill for the Midland Health Board. There were also plans for an extended care unit. The terms ''extended care'' or ''step down'' often implied a passive non-rehabilitative function and the Inspectorate would prefer such rehabilitation units to be community-based.

A written policy for ordering, prescribing, storing and administering medicines was required in each clinical area. The medical preparations policy and procedure should contain information on staff responsibilities relating to ordering drugs from the pharmacy, supervising their storage, taking drug stocks and administering drugs to patients. A number of prescription cards were examined and some of them had no date and no signature.

Some of the prescriptions were difficult to read and this indicated a moderate risk of errors. All prescriptions should be individually signed and dated. Discontinued drugs were signed off using the discontinuation column. However, there was an increased risk factor where discontinued prescriptions outnumbered current prescriptions. Thirteen prescriptions in one ward needed to be rewritten. The system for checking emergency drugs in individual wards required review. One emergency drugs box expired on 1 January, 2001 and had not been changed. It was recommended that a system of checking emergency drug boxes on a weekly or monthly basis be implemented.

The number of episodes of seclusion in the service had reduced. There were only six episodes of seclusion involving five patients in 2000 and seclusion had not been used in 2001 up to the day of inspection. The seclusion policy was last reviewed in 1995 and it should be updated. A seclusion register was maintained and fifteen-minute nursing observations of patients in seclusion were recorded. There were thirty-six spans of special one-to-one nursing supervision involving nine patients in St Loman's Hospital in 2000. A written policy on special nursing supervision was required as it was noted in a number of files that patients were to be ''closely observed''. However, there was no clear criteria as to what this meant. Writing ''closely observed'' in the absence of specific levels of observation and criteria made it impossible to determine the reliability of observation undertaken and the efficiency of special one-to-one nursing supervision.

In 2000, 102 patients discharged themselves from the service against medical advice. Follow-up procedures were in place if considered medically appropriate. Discharged patients should be given a standard information form with details of any drugs prescribed, the name of their GP and the telephone number of the Mental Health Centre or service where staff could be contacted in case of an emergency. Discharge documentation should be in triplicate — one for the patient, one for the medical file and one for the services responsible for follow-up care. There were 176 accidents/incidents to patients and forty-three accidents to staff at St Loman's in 2000. Twenty assaults on patients by other patients and seventeen assaults on staff were also recorded. None were serious. Documentary procedures for reporting accidents and assaults within the service were all satisfactory.

A number of medical records were examined. It should be emphasised that the Longford/Westmeath Mental Health Service was about to introduce a comprehensive new medical file and was changing over to the new system at the time of inspection. As only one or two files had changed over to the new system, the medical records examined were from the older filing system. There were written instructions on filing documentation and the admission sheet was comprehensive. Pathways to admission were clearly documented as was the history of presenting complaint, past history, personal history, family history, mental state examination and physical examination. A clear immediate management plan was also recorded. Current medication and dose were not always recorded in the notes examined. Space to record patients' names on each continuation page was provided but it was not always done. The full signature and designation of the person making entries in the medical notes was required. Date and time of entry should also be recorded. Signatures were not always clear and it was suggested that the professional making an entry should write their name in capitals, sign the entry and record their designation to ensure

easier future identification. Follow-up plans for discharged patients, discharge medication and dosage were also clearly stated.

The quality of nursing documentation varied but was generally unsatisfactory. The nurse care planning system using the 'Roy Model' of nursing no longer seemed to be used and basic nursing notes were kept. In some of the long-stay wards, notes were only recorded each month. A comprehensive audit of nursing documentation needed to be undertaken to assess the standard of record-keeping and to identify areas for improvement and staff development. On-going staff training on a nurse care planning system should be introduced. The new nursing system, involving an appropriate model of nursing, should reflect the involvement of patients in planning and making choices and decisions about their care and treatment and evaluations of nursing care plans should include patients' views about their progress and any changes in the plans.

The service management team met each month and kept records of decisions taken. Health and safety statements were under review at the time of inspection. Fire precautions at St Loman's Hospital were satisfactory but they were unsatisfactory in the Longford community residences and required immediate attention. There was an informal induction process for all new staff but no records were kept. The induction process should be formalised and records of persons involved in the induction process and the areas covered on the induction course should be kept. Appropriate training programmes should be introduced for patients in long-stay wards, community residences and day centres to familiarise them with the new Euro currency. Preparing patients would help make the changeover as stress-free as possible.

A number of patients in the male admission unit were asked for their views on the level of service provided. Patients were asked about issues such as quality of information provided and aspects of their care to highlight areas where the local service needed to make improvements. All of the patients interviewed were satisfied with the admission process to St Loman's Hospital and felt they had access to the service when required. Patients knew the name of their consultant psychiatrist and saw him/her on average three times per week whilst hospitalised. Patients were generally satisfied with the quality and quantity of food provided and with all aspects of hygiene in the toilets and bathrooms. They were aware of their rights under the Mental Treatment Act, 1945 and on how to make a complaint if they felt aggrieved. Patients described the ward environment as ''adequate for a hospital'' but one patient described the decor as dull. Patients remarked on the lack of activities whilst hospitalised and felt that their stay in hospital would be significantly improved if they had access to more activities.

Patients had access to hot and cold drinks and were allowed outside either accompanied or unaccompanied. They remarked on the lack of storage space for clothing and personal belongings but were positive about the facilities available to wash their clothes. They were also satisfied with the level of privacy when being given information or advice about their treatment. Patients reported that illegal drugs were being used on the wards and one patient reported that they were readily available to patients. All patients were satisfied with the care provided and were actively involved in decisions affecting their care. Patients

were satisfied that they had not been obliged to repeat information about themselves to different professionals involved in their care and this was an indication of good teamwork between the various professionals of the multidisciplinary team. The patients interviewed had previously been hospitalised in St Loman's Hospital and, when asked if things had improved since their last admission, all of the patients felt there had been some minor improvements in overall ward facilities.

RECOMMENDATIONS

It is recommended that:—

1. The acute psychiatric unit in Mullingar General Hospital be advanced as quickly as possible.
2. St Brigid's block be de-designated and used as an integral part of the later life service.
3. A day hospital and sector headquarters be provided in Athlone in the new development being planned for the town.
4. The day centre be moved from the Longford day hospital to allow that premises to function as a true day hospital and deal with more disturbed patients.
5. A rehabilitation team be set up to explore and initiate rehabilitation for the long-stay younger population in St Loman's. In conjunction with this, suitable residential accommodation should be provided to accommodate patients in St Loman's Hospital.

CHAPTER FOUR

Mid-Western Health Board

CLARE MENTAL HEALTH SERVICE — 2001 INSPECTION

INSPECTED ON 12 AND 13 SEPTEMBER, 2001

GENERAL DESCRIPTION OF THE SERVICE

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

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

IN-PATIENT CARE

In-patient care was provided at Our Lady's Hospital, Ennis where 187 beds were provided in four male, one female and three integrated wards.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	2	12	8	—	2	24	12.83
3-12 Months	—	—	5	6	1	2	14	7.49
1-5 Years	—	—	4	22	21	3	50	26.74
> 5 Years	—	—	9	49	25	16	99	52.94
All Lengths of Stay	—	2	30	85	47	23	187	100
% of Total	—	1.07	16.04	45.46	25.13	12.30	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
6	81	7	24	16	2
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
5	8	4	33	1	187

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	110	56	166
Temporary	4	5	9
P.U.M.	9	3	12
Ward of Court	(3)*	(1)*	(4)*
Total	123	64	187

*ıncluded in overall totals

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 507
Number of first admissions in 2000 137
Number of discharges in 2000 506
Number of deaths in 2000.....4

Legal status of admissions
Voluntary.....88.8%
Non-voluntary 11.2%

The number of admissions represented an admission rate of 5.5 per 1,000 of the catchment population. First admissions accounted for twenty-seven per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	4	49	900
Day Centres	3	70	163
Out-patient clinics	12	553*	947

*No. of out-patient clinics held in 2000

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
6	27	5	38	2	29

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
10	12	194	41	12.68

COST

The cost of the Clare Mental Health Service was £13.1 (€16.6) million in 2000.

GENERAL COMMENTS

It was disappointing to note that the in-patient component of the Clare Mental Health Service still remained in Our Lady‘s Hospital, Ennis. The expectation at the time of this inspection was that Our Lady‘s would have closed and been handed over to its purchaser,

the Shannon Development Company, and its patients relocated to the various facilities which had been prepared for them throughout the county. This had not happened because industrial relations negotiations had not yet concluded. The Board had made a generous offer to nursing unions which was rejected at ballot and a re-negotiation had to take place. Agreement with support staff who would also move with patients to their new locations had not been reached either. Although the alternative accommodation was ready to receive patients, the new psychiatric unit in Ennis General Hospital had not yet been handed over by the constructors nor had it been commissioned. However, it was anticipated that the unit would be ready for patients within two months of the inspection.

There were 169 patients in Our Lady's Hospital on the day on inspection. Forty per cent were over sixty-five years of age and twenty per cent had an intellectual disability. Fifteen patients became new long-stay patients in 2000 and eighteen of these were over sixty-five years of age. Conditions in Our Lady's Hospital had deteriorated further since the previous inspection which made its closure even more urgent. The Inspectorate, the Mid-Western Health Board and the Department of Health and Children could not defend the conditions that obtained in St Anthony's and St Paul's male wards in particular. The two admission wards, while decoratively and hygienically of a higher standard, were quite unsuited to modern acute psychiatric admission practice and, more disturbingly, were both constantly locked.

The range of community services was quite extensive and was being continuously augmented. When complete, in a few years time, there should be multidisciplinary teams working out of mental health centres/sector headquarters/day hospitals in all four sectors. Already, much of this was in place in Kilrush for the West Clare sector. In Ennistymon (the North Clare sector), the existing residential, day hospital and day centre premises was to be improved and extended. Plans had been drawn up and funds were available for extending the existing facilities for South Clare in Shannon and work was already underway to enlarge the day hospital premises in Ennis which served East Clare. In addition, a new day centre was being provided in Scarriff. The philosophy and practice of care to which the service was committed envisaged that an outreach, home-based programme would operate from each of these sector headquarters as it already did in Kilrush and Ennis. This commitment to rational and comprehensive community-based care delivery was refreshing and staff appeared to welcome it.

A consultant in later life psychiatry had taken up a post in the service and would have a five-bed acute assessment unit in the new acute psychiatric unit, Ennis General Hospital. However, the infrastructure for this post, including continuing care facilities and a multidisciplinary team, was not yet in place. It was hoped that these essential requisites would be put in place as soon as possible. An application had been made for a consultant-led rehabilitation team. It was felt that this would be an important addition to the Clare service and would include among its physical resources the rehabilitation/crisis outreach/crisis bed provision unit at Téach na mBéatha, which was to be enlarged for this purpose. Child psychiatric services in Clare were unsatisfactory. They were provided on a sessional basis from Limerick by one of the existing child psychiatrists. It was hoped to

create an additional post for the area, with the new appointee being exclusively responsible for services in Clare.

All of the locations being prepared to receive patients from Our Lady's Hospital were inspected and all were impressive. In Ennis, the Cappahard nursing home, bought from the private sector, offered very comfortable accommodation for forty-eight older persons. It was well decorated and furnished. On the campus of Our Lady's, the Board, in conjunction with the RESPOND housing agency, had constructed and equipped three bungalows in a social housing complex with a central community centre for nineteen intellectual disability patients. These premises were ready to receive patients. In Kilrush, the Orchard residence was to receive thirty long-stay patients from St Patrick's and St Joseph's Wards. This premises also accommodated the Kilrush day centre which would be available to the new arrivals. The former convent premises, Gort Glas on the Lifford Road, Ennis, had been converted and was ready to receive twenty long-stay patients. In Spanish Point, a one-storey modern building — Cois Mhara — would offer comfortable facilities for patients from St Anthony's Ward in a highly-staffed setting. The premises could be justifiably called a 'residential ward', the first of its kind in Ireland. While the first patients would all be male, its layout easily allowed for the accommodation of female patients. The building, with fine sea views, was not isolated but the back-yard did have ten-foot high walls. It was hoped to landscape the area and cover the high walls with climbing plants. A further seven patients were to move to Ard na Gréine, a new residence in Ennis. The residence was occupied by patients from the Tulla Road residence at the time of inspection who had been moved while improvements were being carried out in Tulla Road.

The new forty-bed acute psychiatric unit at Ennis General Hospital was almost ready. It was a single-storey, triangular building with an internal cloister, located behind the main hospital building but linked to it by a corridor. It also had an independent rear entrance. It comprised a spacious self-contained five-bed sub-unit for older persons with its own internal courtyard and dining area; a nine-bed intensive care sub-unit with its own entrance door and separate courtyard which could be observed from the central nurses' station of the main adult unit. It comprised three single rooms, two three-bed rooms and a day/dining area. The third and largest component was the thirty-one bed main adult unit. The new unit was welcomed and would be a significant improvement on the unsatisfactory admission accommodation provided at Our Lady's. However, there were some reservations about the provision of a separate intensive care unit. The primary issue was whether such a sub-unit should be provided within a modern general hospital psychiatric unit. The number of disturbed patients coming to this sub-unit should never reach the quota provided. The large circular nurses' observation station, which controlled and oversaw both the main adult area and the intensive care area, had television monitors covering all the single rooms and both the three-bed rooms. The Inspectorate did not approve of the use of closed-circuit television monitoring as it was felt to be an invasion of privacy and quite unnecessary in the three-bed areas and in single rooms not used for seclusion purposes.

The Mid-Western Health Board had made an application to the Department of Health and Children for a regional intensive care unit. With the provision of the residential unit

and the nine-place intensive care/high observation unit in Ennis General Hospital, it could be argued that there was adequate provision for such patients without recourse to a regional intensive care unit, at least as far as County Clare was concerned. The Board had obtained approval for a consultant forensic psychiatrist post and had suggested that the regional forensic psychiatric service be set up as a national pilot project. It was proposed that this new forensic consultant would provide one session per week to the Clare service.

The Inspectorate had to compliment the Clare service on its adoption of the patient case record system first developed by the Limerick service, which it regarded as the most satisfactory one in the country. It had order, sequence and integration and instructions for usage and completion appended to it. However, it was noted that, in common with every other Irish service, the ICD diagnosis was generally not entered in the appropriate place on the record. Otherwise, medical records and case notes were appropriate, frequent, legible and signed in full. Drug prescribing practices were also satisfactory.

Admissions to in-patient care at Our Lady's were mainly selective and decided by consultants. However, some patients were referred by GPs or self-referred and were evaluated and assessed by the NCHD on call who conferred with the sector or duty consultant in most instances before deciding whether to admit or refer to more appropriate alternative care. When referred elsewhere, an 'assessment and referral' form was completed and a copy was sent to the day hospital or mental health centre to which the patient was referred. This was a satisfactory procedure and the Inspectorate was happy to see it in place. A system for observing and supervising patients, including the use of closed-circuit television in the new acute unit, had been drawn up. While this document was approved of in principle, the Inspectorate had serious reservations relating to the use of closed-circuit television monitoring of patients.

While the delay in moving patients from Our Lady's Hospital to the acute unit and community facilities was regrettable, the Inspectorate acknowledged the considerable amount of work and the degree of imagination and commitment utilised in bringing about the not inconsiderable task of closing a psychiatric hospital such as Our Lady's. It was hoped that the last remaining hurdle, that of satisfactory industrial relations negotiation, would soon conclude, particularly as a facilitator was likely to be appointed to progress matters between administration and the unions. It was planned to re-visit the service shortly after the patients moved to see how they settled in, particularly in the acute unit.

There were no recorded episodes of seclusion in the service for 2000. However, it was mentioned that some patients were placed in the quiet room in the admission unit for observation or 'time out' and it appeared that some patients were actually secluded. The Inspectorate was not happy with the use of a single glazed room adjacent to the nurses' station in the female admission unit for the purpose of seclusion. Patients were placed in this room with the door locked without the event being recorded in the statutory seclusion book. This practice was illegal and the importance of complying with the legal requirements was stressed. There was a written policy and procedure on seclusion in the service

which should be strictly adhered to in relation to all episodes of seclusion. Written seclusion orders should be maintained in the seclusion register as set out in the Mental Treatment Act, 1945 and amending legislation. Records of fifteen-minute nursing observations should also be recorded in a separate nursing seclusion care plan.

It was reported that there had been thirty-five episodes of special one-to-one nursing since 1 January, 2001. Twelve patients were prescribed ECT in 2000. Three patients had their temporary admission orders extended in the same year. No recorded complaints or appeals were made, by patients or relatives of patients, to the local complaints/appeals manager in 2000. One research project governed by the Clinical Trials Act 1987 — 1990 was undertaken by the hospital and all appropriate procedures relating to the clinical trial were followed. Thirteen accidents to patients and three to staff were recorded in 2000 and none were deemed serious. There were no recorded assaults on patients by other patients but eight assaults on staff were recorded and none were deemed serious.

A written drugs policy and procedure was available in local areas for staff information and reference. This comprehensive policy was last reviewed and dated in June 1999. A number of individual prescriptions picked at random were examined. There was a very low risk factor of administering incorrect medication as most prescriptions were in block writing and those that were scripted were not difficult to read. This was satisfactory. All prescriptions were dated individually and signed. It was suggested that the full signature of the person prescribing should be entered in order to identify the practitioner in the future. There was provision for recording drug allergies within the documentation to ensure that information was readily available to staff. Discontinued drugs were not always signed off using the discontinuation column and this required attention. There was an increased risk factor of drug error on a small number of prescriptions where the number of discontinued prescriptions exceeded current prescriptions. Prescribed medication was clearly recorded in case notes examined. The written safety statement for the hospital adhered to the standards and procedures set by the Safety and Welfare In Work Act, 1989. The safety statement was dated 1993 and needed to be reviewed and updated. It should be available in each local area and hazard control documentation indicating periodic safety audits should be also available.

The nursing record was incorporated into the clinical notes and the ‘Orem/King model’ of nursing was used. Records examined in the admission unit confirmed that patients appeared to settle into the ward at the end of their first day in hospital. Entries seemed to be made as soon as possible after the events to which they related. The patient’s name was appropriately recorded on each continuation page and the records themselves had been audited to assess the standard of record-keeping and to identify areas for improvement and staff development. No abbreviations were noted in the records examined. The records identified problems that had arisen and actions taken to rectify them. The service was considering introducing a nurse key worker system and this initiative was welcomed. Ideally, nursing should reflect the involvement of patients in planning and making decisions about their care and treatment. Entries in the notes should contain information on a patient’s wishes, preferences and suggestions about treatment approaches. Similarly,

evaluations of nursing care plans should include the patient's own views about progress and any negotiated changes in care plans.

The medical records provided space for the patient's name and personnel number on the outer cover which enabled easy identification. Written instructions on filing within the record was printed inside the front cover. The record included a detailed mental health assessment form, a nursing assessment form, out-patient and in-patient notes which provided space for the patient's name, date of birth and record number on each continuation page. There was also a section for ECT forms, drugs, diet, rating sheets, current treatment and leave periods from hospital. The clinical documentation in this service was of a high standard.

Patients in the admission units were interviewed to ascertain their views on the level of service provided. While generally uncomplaining, some unsurprising points were made including complaints about both admission wards being locked which resulted in difficulties getting outside in fine weather and for visitors coming to see patients, the lack of privacy in the large undivided dormitories and the broken washing machine in the female ward. Likewise, accommodation for patients who smoked was extremely limited and, as a result, non-smoking patients were exposed to passive smoking in the day areas and the dormitories, a practice that should not be allowed. Patients knew the name of their consultant psychiatrist, were informed about the nature of their medical condition and were generally satisfied with the admission process and courtesy and helpfulness of staff. Some patients were aware of their rights under the Mental Treatment Act, 1945 and amending legislation as they had read the notices prominently displayed in the ward area. Other patients were aware of the notices but had not read them.

Patients reported that it was possible to get a good night's sleep in the dormitory areas. They had adequate access to washing and shower facilities. They reported a lack of privacy for family and friends visiting and one female patient complained that there were no curtains around her bed. Storage space for clothing and personal belongings was adequate and there was adequate respect for privacy when being given treatment or advice. Those interviewed felt that the ward needed to be redecorated but they understood that the ward was due to close with the relocation to Ennis General Hospital. One patient requested that nurses spend more time talking to patients. The patients interviewed were not aware if there was a nurse with primary responsibility for their care. They were generally satisfied with the explanations given to them about their treatment, including medication and its long- and short-term effects. One female patient requested access to a psychologist and another female patient said that she would like to see her doctor more often.

RECOMMENDATIONS

In the light of the changes that were to take place in this service in the months following the inspection, the Inspectorate refrained from making any recommendations other than the obvious one that Our Lady's Hospital should close as soon as possible and the patients moved to their new locations. When this happened, the situation would be reviewed and recommendations made as appropriate.

LIMERICK MENTAL HEALTH SERVICE — 2001 INSPECTION

INSPECTED ON 23 AND 24 OCTOBER, 2001

GENERAL DESCRIPTION OF THE SERVICE

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

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

IN-PATIENT CARE

In-patient care was provided at St Joseph's Hospital, Limerick where 193 beds were provided in five male, three female and two integrated wards and at the fifty-bed acute psychiatric unit, Limerick Regional Hospital.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	3	28	13	7	3	54	22.79
3-12 Months	—	1	11	6	3	1	22	9.28
1-5 Years	—	—	6	13	5	3	27	11.39
> 5 Years	—	—	13	64	37	20	134	56.54
All Lengths of Stay	—	4	58	96	52	27	237	100
% of Total	—	1.69	24.47	40.51	21.94	11.39	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
11	87	1	20	26	5
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
6	10	3	64	4	237

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	127	81	208
Temporary	7	6	13
P.U.M.	9	6	15
Ward of Court	(2)*	(6)*	(8)*
Informal	1	—	1
Total	144	93	237

*included in overall totals

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 779
Number of first admissions in 2000 191
Number of discharges in 2000 765
Number of deaths in 2000 16

Legal status of admissions
Voluntary 88.7%
Non-voluntary 11.3%

The number of admissions represented an admission rate of 4.7 per 1,000 of the catchment population. First admissions accounted for 24.5 per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	5	125	1,315
Day Centres	3	65	122
Out-patient clinics	7	1,358*	1,958

*No. of out-patient clinics held in 2000

Community Residences

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

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
12.3	17	306	64.09	13

COST

The cost of the Limerick Mental Health Service was £16.9 (€21.5) million in 2000.

GENERAL COMMENTS

Since the 2000 inspection, three units in St Joseph's Hospital had closed with the transfer of thirty-six intellectual disability patients to specialised residential facilities at Lisnagry. A new day hospital, Inis Cara, had opened in Limerick and a custom-built new day centre, Ivy Gate, had opened in Kilmallock. Both were well designed and provided appropriate decor and furnishings. Finally, a liaison psychiatry nursing service in the A & E Department of Limerick Regional Hospital had been put in place. It operated between 4 p.m. and 3.00 a.m. and was to be strengthened by the appointment of a full-time liaison consultant psychiatrist.

The five sectors of the Limerick service were reasonably well equipped with day hospitals, day centres and community residences. Some of the day hospitals functioned as sector

headquarters with full multidisciplinary teams working from them. However, this had not been achieved in all cases; in one instance the medical presence was sessional and concerned mainly with attending to out-patients attending the day facility. All five day hospitals provided out-patient clinic facilities with the result that they were often swamped and diminished by this activity. None had enough space to cope with even moderately disturbed patients which limited the range of patients which could be dealt with in a community setting. The Inspectorate was unhappy with this arrangement and would prefer to see out-patient clinics held on a different site to day hospital premises. For the same reason of limited space, some day hospital premises were unable to act as sector headquarters or effective mental health centres accommodating full-time teams. Some teams were not truly multidisciplinary because of the shortage of psychologists, social workers and occupational therapists. It was hoped that these limitations would be overcome because the principles of sectorisation, working in the community and teamwork was well understood and practised in the Limerick service.

Despite considerable upgrading and improvement, Unit 5B remained unsuitable for its purpose of catering for acutely ill patients. This was largely due to the limitations imposed by its layout, which greatly compromised efficient observation and may have partly accounted for the unit being almost constantly locked and the high level of special nursing supervision. The situation was not helped by the mandatory arrangement for persons under sixteen years of age to have a special nurse. Three children under sixteen years of age were in the unit on the day of inspection and, during 2000, fifteen children under sixteen years of age were admitted to the unit. This was a totally unacceptable situation and created problems for both the children and the staff. Despite the locked door and the high level of special nursing, there were eighty-four patient transfers from Unit 5B to St Joseph's Hospital during 2000. The later life psychiatry service admitted patients to Unit 5B but not to a designated unit — although one six-bed unit was used for these patients as far as possible. The 'intensive care' sub-unit, which had never functioned as such or for any other purpose, was still vacant. It should be possible to remodel and convert it into a self-contained unit for older patients, which would greatly improve their care. At the time of inspection of Unit 5B, there were no activities for patients despite the recent appointment of a co-ordinator of such programmes. A professional occupational therapist attended the unit for a limited number of sessions per week. The fire safety arrangements in Unit 5B were a matter of concern; it was pointed out by a patient that all fire emergency exits were locked and could only be opened by staff members. A more rigid approach to regular fire drills also appeared to be necessary.

The view had been expressed in some quarters that additional acute or sub-acute beds were needed for 'step-down' purposes from the acute unit. The Inspectorate was not convinced by this argument, both in principle and in relation to this particular service, and felt that the present number of beds was adequate for the catchment area. Before any suggestions of this nature were made, a more active scrutiny of existing acute bed use should be undertaken. It was noted, for example, that the average length of stay of patients in Unit 5B was almost three weeks and that almost one-fifth of admissions were alcohol-related, most of which could probably be dealt with by alternative approaches. It was also pointed out that, while most admission decisions were made appropriately in day hospital

settings, these decisions were not always made by consultants. If they were, it could conceivably reduce the number of inappropriate admissions.

The reduction in the number of patients in St Joseph's Hospital from approximately 800 to 150 over the past fifteen years was remarkable. Most recently, the progress had continued with the transfer of thirty-six intellectual disability patients to Lisnagry. Nonetheless, the task of resettling the remaining patients from St Joseph's was formidable. Of the 150 remaining patients, approximately forty were older persons residing in two wards; two other wards catered for long-stay patients with considerable psychiatric impairment; a fifth ward catered for a mix of longer-stay patients and those transferred from Unit 5B. Approximately twenty longer-stay intellectually disabled patients were distributed throughout the five wards. Their community resettlement hinged on two requirements; active rehabilitation and appropriate community residential accommodation. The Inspectorate felt that a specialised consultant-led rehabilitation team should be appointed to the Limerick service, which had a greater need than the Clare service for which a consultant-led rehabilitation team had already been approved. The community residential accommodation required should be high-support and should include at least one 'residential ward' type facility i.e. a residence with a high level of physical and professional support.

A large premises, a former nursing home called Villa Maria, had been purchased for the Limerick Mental Health Service at Raheen in south Clare. It was to be adapted and would then serve as a facility for older persons, specifically those residing in St Teresa's Ward in St Joseph's Hospital. St Teresa's Ward was overcrowded and in deteriorating condition. Apparently, the Board felt that St Teresa's should be refurbished and allocated to the forensic psychiatric service for in-patient purposes. The Board was seeking approval for this post. The Inspectorate was not convinced that the numbers in Limerick prison and the community criminal justice service in the Limerick area was large enough (this has not been formally or scientifically ascertained) to justify such a large number of in-patient beds in the mental health service. This was without considering putting in place a psychiatric observation and intervention centre within Limerick Prison itself. The Inspectorate felt it would be more appropriate to use the refurbished St Teresa's Ward to improve the unacceptable conditions in which some of the long-stay patients in St Joseph's resided. It should be stressed that conditions, particularly in St Martin's Ward, were very poor and alternatives were needed urgently. While some minor upgrading and repainting was underway, the fundamental unsuitability of these wards for long-stay patients was not being addressed. A number of long-stay patients were still classified as persons of unsound mind; the Inspectorate felt that these patients should be allowed change their status to voluntary patients where appropriate or else become temporary patients.

The community services of Tipperary North Riding, which were extremely limited, were being provided by the Mid-Western Health Board while the consultants and in-patient care were provided by the Tipperary Mental Health Service at St Luke's Hospital, Clonmel. The Inspectorate had some doubts about the proposal to provide an independent mental health service for Tipperary North Riding based on an in-patient unit in Nenagh General. It was felt that a separate, independent service for such a population base (50,000) would not be cost-efficient. It would be more appropriate to put a comprehensive

community resource in place in Tipperary North Riding with access to Unit 5B where only a limited number of in-patient beds would be required.

There were seventeen episodes of seclusion involving six patients in St Joseph's Hospital during 2000 and an appropriate seclusion register was maintained. There had been twenty-four episodes involving five patients in St Rita's Ward to date in 2001. Fifteen-minute nursing observations of all patients placed on seclusion were appropriately recorded. A written seclusion policy and procedure was available. It should be signed and dated. Some seclusion authorisations were prescribed by junior doctors and, on checking some medical notes, there was no written medical assessment of the patient prior to or following seclusion episodes. Nursing notes relating to all seclusion episodes were satisfactory.

There were 2,210 spans of special nursing supervision involving forty-one patients at Unit 5B, Limerick Regional Hospital and 152 spans involving ten patients at St Joseph's Hospital, Limerick in 2000. Whilst the number of patients placed on special nursing supervision at Unit 5B had decreased from fifty-seven patients in 1999 to forty-one, the use of special nursing had increased from 1,700 to 2,210 spans. While a risk assessment which took the patient's clinical condition and the environment in which the special nursing supervision was provided was taken into account, the degree of supervision required to ensure the safety of the patient, other patients and staff should be considered under three headings: Grade 1 — special one-to-one constant supervision, Grade 2 — prescribed recorded observation, where the patient is observed at least every fifteen minutes or other intervals as prescribed with appropriate records of all observations and Grade 3 — ordinary observation, where the patient is required to remain on the unit. An in-depth audit should be conducted on the use of special nursing supervision at Unit 5B.

Three patients had their temporary admission orders extended during 2000. Fifteen accidents to staff and 117 accidents to patients were recorded in the Limerick service during 2000. Ten required further medical intervention. Fifty-six assaults on patients by other patients and fifty-four assaults on staff were recorded. Twenty-two patient assaults and forty-eight staff assaults required further medical intervention. Forty-eight patients in Unit 5B were prescribed ECT in 2000. Seventeen in-patients discharged themselves from hospital against medical advice in the same year and appropriate arrangements were in place to follow up patients. Twenty-seven complaints/appeals by patients or their relatives were made to the local complaints/appeals managers in the hospitals in 2000 and all appeared to have been dealt with satisfactorily.

The standard of medical and nursing records within the Limerick Mental Health Service was high. Written instructions on maintaining and filing documentation within the records were available, as were guidance notes on the order of assembly of the integrated file. All medical notes examined were comprehensive and satisfactory. The patient's name and date of birth were recorded on each page. Pathways to admission were appropriately recorded and the Mental Health Assessment Form was comprehensive. Nursing notes were examined at Unit 5B where the 'Orem/King Nursing Model' was used. Appropriate training on the nurse care planning system was available. The records examined confirmed that patients settled into the ward at the end of their first day of hospitalisation. All entries

appeared to have been made as soon as possible after events to which they related. By and large, records identified problems that had arisen and action taken to rectify them. All entries were dated accurately and no abbreviations were noted on the records examined. Nursing entries should record patients' wishes, preferences and suggestions about treatment approaches to ensure the involvement of patients in making choices and decisions about their own care and treatment. Similarly, evaluation of nursing care plans should include patients' views about progress.

There was a written drugs policy and procedure for the service, which was last reviewed in 1998. A number of prescription cards and drug administration cards were examined. The overall standard of the prescriptions varied. The majority were individually signed and dated. Scripted prescriptions were not difficult to read and changes on prescriptions were written as new prescriptions. Drug allergies were recorded so that information was readily available to staff and discontinued drugs were signed off using the discontinuation column. On a small number of prescriptions examined, the number of discontinued prescriptions exceeded the number of current prescriptions. These should be rewritten as they posed an increased risk of drug administration error. Prescribed medication was appropriately recorded in the medical case notes. Verbal information on medications was provided to patients. Ideally, the notes should record when and how this information was given to patients with a comment on the patient's understanding of the information provided.

A number of patients in Unit 5B were interviewed to ascertain their views on the level of service provided. They were generally satisfied with the admission process and the courtesy and helpfulness of staff. They knew the name of their consultant psychiatrist and felt they had adequate access to them whilst hospitalised. They all felt they were informed about the nature of their medical condition, including medication and treatment, and, with one exception, they all reported that they understood what was explained to them. The patients interviewed reported not being informed about their rights under the Mental Treatment Act, 1945 or on how to make a complaint if they felt aggrieved. Patients reported adequate storage space for personal clothing and belongings and facilities to wash clothing were available. All were satisfied with the facilities provided for visitors and with the sleeping arrangements. Patients were generally satisfied with the cleanliness of toilets and bathrooms, although one patient reported that at times the bathrooms required greater attention.

All patients reported that the public address system in Unit 5B was irritating. One patient reported that the speakers in one part of the unit were malfunctioning and some reported a lack of privacy in relation to the public address system. Patients interviewed appeared to accept that locking the external ward door was normal as none had any complaints about this. Patients reported easy access to a telephone and hot and cold drinks. Those interviewed were aware that there was a nurse with primary responsibility for their care. Nurses were allocated on a sector basis and patients got their information from the ward notice board. One patient complained about a lack of continuity due to frequent changes of nursing staff and one patient reported that the doctors and nurses always seemed to be in a hurry and very busy and that patients had to go looking for them for information. It

was suggested by this patient that the nursing staff needed to be more involved with patients and to ensure that information on prescribed medication was given to them. One patient reported that she was waiting over three weeks to see the psychiatric social worker. All patients interviewed had been hospitalised previously in Unit 5B and all reported some improvement in the overall facilities since their previous admission. One patient suggested an in-depth review of fire safety procedures in the unit in view of the locking of external ward doors. It was an appropriate concern that required continuous review.

RECOMMENDATIONS

It is recommended that:—

1. Alternative community-based accommodation be provided as soon as possible for the long-stay residents of St Joseph's to replace their current unacceptable living conditions.
2. Alternative in-patient accommodation be provided for the needs of children on a regional basis to end the unacceptable practice of admitting them to an adult psychiatric unit.
3. Existing day hospitals be enlarged to enable them to serve as sector headquarters and to deal with a wider range of severely ill patients.
4. A full-time consultant-led rehabilitation team be established.
5. The sector teams be strengthened to provide a true multidisciplinary focus through the recruitment of psychologists, social workers and occupational therapists.

CHAPTER FIVE

North-Eastern Health Board

CAVAN/MONAGHAN MENTAL HEALTH SERVICE — 2001 INSPECTION

INSPECTED ON 21 AUGUST, 2001

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 104,000 was divided into four sectors as follows:—

Sector	Population
North Monaghan	28,000
South Monaghan	24,000
West Cavan	30,000
East Cavan	22,000

IN-PATIENT CARE

In-patient care was provided at St. Davnet's Hospital, Monaghan where seventy-five beds were provided in two male, two female and one integrated ward and at the twenty-bed integrated psychiatric unit, Cavan General Hospital.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	1	3	6	1	11	14.47
3-12 Months	—	—	1	—	—	—	1	1.32
1-5 Years	—	—	—	2	6	2	10	13.16
> 5 Years	—	—	2	10	14	28	54	71.05
All Lengths of Stay	—	—	4	15	26	31	76	100
% of Total	—	—	5.26	19.74	34.21	40.79	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
6	42	3	6	10	8
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
—	1	—	—	—	76

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	28	37	65
Temporary	1	2	3
P.U.M.	—	8	8
Ward of Court	—	(2)*	(2)*
Total	29	47	76

*Included in overall totals

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 224
Number of first admissions in 2000 79
Number of discharges in 2000 236
Number of deaths in 2000 9

Legal status of admissions
Voluntary 86.2%
Non-voluntary 13.8%

The number of admissions represented an admission rate of 2.1 per 1,000 of the catchment population. First admissions accounted for thirty-five per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	2	35	123
Day Centres	3	65	124
Out-patient clinics	8	521*	1,771

*No. of out-patient clinics held in 2000

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
12	53	5	60	—	—

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
17	19.2	197.66	76.81	6

COST

The budget for the Cavan/Monaghan Mental Health Service was £11.1 (€14.1) million in 2000.

GENERAL COMMENTS

The Cavan/Monaghan Mental Health Service was divided into four major service components. There were two home-based care delivery services for acute illness, one based in St Davnet's Hospital serving County Monaghan and one based in the Psychiatric Unit,

Cavan General Hospital serving County Cavan. They operated a seven-day week from 9.00 a.m. to 9.00 p.m. The third component, which covered both counties, was the rehabilitation service based at St Davnet's Hospital. The fourth component, the later life psychiatry service, was also based at St Davnet's Hospital. All four components had their own consultant-led multidisciplinary team with appropriate administrative and clerical support.

The 'new' approach to care delivery in this service had resulted in a sharp decline in the number of acute in-patient admissions. There were only sixteen patients in both acute units on the day of inspection and this was above average. In addition, there were sixty-six patients in four other wards in St Davnet's Hospital. Twenty-four were younger long-stay patients in need of rehabilitation and for whom community residential accommodation was required. A residence for this purpose was to be constructed on the grounds of St Davnet's in the near future. The remaining forty-two patients, the majority of whom were over seventy-five years of age, had their physical care provided by a GP and their psychiatric care provided by the specialist consultant in later life psychiatry.

It was the ambition of the service to provide a sector headquarters and mental health centre in the four catchment area sectors. Work on the provision of such a facility in Carrickmacross for South Monaghan was due to start shortly after the inspection. Similar plans to build a multi-purpose health development facility for South Cavan in Virginia were in place and the premises at Bailieboro for the North Cavan sector were to be improved and extended. Although there was a strong commitment for such a provision, no adequate premises were available in North Monaghan and there were no immediate plans to provide a sector headquarters and mental health centre there. As a result, the day services for Monaghan were based in St Davnet's Hospital rather than in the community. In addition to the provision of an appropriate physical infrastructure, there was a commitment to providing true multidisciplinary teams in each of the four sectors. To this end, existing occupational therapy and psychology resources needed to be strengthened.

The later life psychiatry service was working well and had an acute bed allocation in the psychiatric unit, Cavan General Hospital. Although it was not self-contained, it did not pose too much of a problem due to the low occupancy of the unit. Day facilities for the service were provided at the day hospital in the psychiatric unit and in St Davnet's Hospital. Whether other locations for these day services would be more appropriate was being reviewed.

The issue of whether acute psychiatry in the service was best served by two admission units (St Davnet's and Cavan General) or only one at Cavan General was a matter of debate. There were cost issues in relation to staffing as well as other considerations. For example, there was almost a one-to-one nurse staffing arrangement on the day of inspection for the five patients in St Davnet's and it was reported that the number of in-patients sometimes fell below this number. There were also some patients in twenty-four hour staffed community residences who required alternative, less dependent accommodation. Many were older persons who lacked defined activities during the day. Day activities for patients in the two long-stay wards in St Davnet's were also lacking, although an occupational therapist visited the wards each week. The patients in these wards were to move

to community residences and adequate preparatory programmes needed to be put in place for them. Although a certain amount of psychiatric care was required for older patients in St Davnet's, their major requirements related to their physical health. Given this consideration, it was felt that the best interests of these patients would be served by removing them from the psychiatric register by de-designating the two wards, continuing their care with existing staff and providing any necessary psychiatric care through the consultant for later life psychiatry.

There were twenty-six episodes of special one-to-one nursing supervision involving two patients at the psychiatric unit, Cavan General Hospital in 2000. Seclusion was not used in the service. Thirteen patients in the service were prescribed ECT and five patients had their temporary admission orders extended during the year. A medical assessment should be performed prior to any decision to extend a temporary order and the reason for the extension should be recorded in medical notes. An information booklet was available to patients in the admission areas with pertinent information relating to their care. This booklet should contain information on a patient's right of appeal under present legislation and such information should be communicated to patients. Notices conveying this information should be displayed prominently in all in-patient locations.

The overall admission rate for the Cavan/Monaghan Mental Health service was low by national standards. The success of the home-based treatment and the community mental health programmes had resulted in a dramatic reduction in the number of voluntary admissions (overall admissions reduced from 715 in 1992 to 224 in 2000). Only one recorded complaint was made by a patient or relative to the local complaints manager in 2000. Fifty-eight accidents to patients and eleven accidents to staff were recorded in the service during 2000 and none were deemed serious. Eight assaults on a patient by another patient and sixteen assaults on staff were recorded in the same year. Seven staff assaults required further medical intervention.

At the time of inspection, the service was in the process of changing to a new medical recording system. The new medical record had space for the patient's name, address and personal number on the outer cover which enabled easy identification. There was no inside pocket in the new folder, therefore, there was no risk of delay in accessing pertinent information or misfiling information. Clear instructions on filing documentation within the record was provided. The record included information on patient details, clinical contact, assessment record, risk history and medical and nursing clinical notes. Each page of the clinical notes provided space for the patient's name, reference number and location. There was also provision for filing reports, correspondence, notes from home-based treatment teams and community nursing reports.

The written drugs procedure and policy was last reviewed and updated in 1999. The service was in the process of transferring to a new prescription and drug recording system and it was hoped that all areas would change to the new system in the near future. Some of the prescriptions examined at Cavan General Hospital were not signed and some of the signatures were illegible. These matters required attention. There was a need to ensure one date and one full signature for all prescriptions at St Davnet's Hospital. The new system

provided for recording drug sensitivity/allergy/adverse reactions to ensure that information was readily available to staff. Discontinued drugs in all prescriptions examined were signed off using the discontinuation column. In one case, the number of discontinued prescriptions was greater than the number of current prescriptions and it was suggested that this card should be rewritten. The drug administration recording sheet provided for the administration of drugs at 8 a.m., midday, 2 p.m., 6 p.m. and 10 p.m., and at other times as required. There was also provision for the nurse's full signature in the new drug administration recording sheet and periodic auditing of the recording sheet was suggested to ensure compliance with the policy. The practice of administering medicines due at 6 p.m. as early as 4.30 p.m., as observed in some of the long-stay wards in St Davnet's Hospital, should cease.

The quality and content of nursing documentation varied throughout the service. Nursing documentation at Cavan General Hospital was generally satisfactory. The 'Orem Model' of nursing care was being replaced at the admission unit in St Davnet's Hospital but had not been introduced at the time of inspection. It was difficult to evaluate the content of nursing records in the admission unit due to this transition process. The standard of nursing notes in the other wards ranged from basic nursing notes to no notes at all. It was recommended that all nurses making entries in the nursing notes should record their full signature and designation. Some nursing goals written in the nursing kardex file dated from 1996 and there was no correlation between the nursing notes and the nursing goals. In spite of the shortcomings of the nursing notes, the nursing staff caring for older patients provided a high standard of care. Nevertheless, this should be exemplified by developing an effective system of nurse care planning. There was an urgent need to audit nursing records to assess the standard of record-keeping and to identify areas for improvement and staff development. Ideally, nursing records should reflect the involvement of patients in planning and making decisions about their care and treatment. Similarly, nursing evaluations should include patients' views about their progress.

The emergency drug system was checked in the long-stay ward areas and was satisfactory. The oxygen cylinders were checked and it was felt that the checking system should be recorded on a weekly basis. All staff working within in-patient care should wear an identification badge to ensure easier communication between patients, staff and members of the general public. A new guidelines document for clinical staff on patient assessment and management, incorporating guidance notes on clinical and social assessment, risk assessment, risk management and care programme approaches, had been introduced for staff information and reference. Appendices to this report included risk indicators and guidelines on assessment of mental functioning, physical well-being and activities of daily living, including self-care, everyday tasks and work vocational performance.

RECOMMENDATIONS

It is recommended that:—

1. The admission unit at Cavan General Hospital serve as the admission unit for the entire catchment area.

2. The provision of sector headquarters and mental health centres in Carrickmacross and Virginia and the upgrading of the mental health centre at Bailieboro be expedited.
3. Consideration be given to the location of a sector headquarters and mental health centre for North Monaghan in Monaghan town.
4. Preparatory rehabilitative inputs be put in place to facilitate the relocation of patients from the long-stay wards at St Davnet's to community residences.
5. The two remaining elderly care wards at St Davnet's be de-designated as most of the patients' needs were physical rather than psychiatric.
6. Reasons for the extension of temporary admission orders be recorded in the medical notes.
7. Nursing records at St Davnet's be audited to assess the standard of record-keeping and identify areas for improvement.
8. A written policy on locking external ward doors be available at Cavan General Hospital.

LOUTH MENTAL HEALTH SERVICE — 2001 INSPECTION

INSPECTED ON 8 AUGUST, 2001

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 111,193 was divided into three sectors as follows:—

Sector	Population
Mid-Louth/East Meath	31,746
North Louth	45,374
South Louth	34,073

IN-PATIENT CARE

In-patient care was provided at St Brigid's Hospital, Ardee where 120 beds were provided in one male, one female and three integrated units.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	6	9	8	3	26	25.24
3-12 Months	—	—	—	—	—	2	2	1.94
1-5 Years	—	—	2	13	10	7	32	31.07
> 5 Years	—	—	5	18	11	9	43	41.75
All Lengths of Stay	—	—	13	40	29	21	103	100
% of Total	—	—	12.62	38.83	28.16	20.39	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
4	46	1	24	7	—
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
3	3	1	14	—	103

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	35	42	77
Temporary	11	3	14
P.U.M.	2	—	2
Ward of Court	6	4	10
Total	54	49	103

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 430
Number of first admissions in 2000 117
Number of discharges in 2000 447
Number of deaths in 2000.....6

Legal status of admissions
Voluntary.....90.9%
Non-voluntary 9.1%

The number of admissions represented an admission rate of 3.9 per 1,000 of the catchment population. First admissions accounted for twenty-seven per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	—	—	—
Day Centres	2	77	101
Out-patient clinics	5	215*	823

*No. of out-patient clinics held in 2000

Community Residences

Low Support		Medium Support		High Support	
No. of residences	**No. of places**	**No. of residences**	**No. of places**	**No. of residences**	**No. of places**
2	12	—	—	3	48

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
8	19	147	56	9.82

COST

The budget for the Louth Mental Health Service was £8.2 (€10.4) million in 2000.

GENERAL COMMENTS

Division of the Louth sectors was seen to be imperative with the appointment of a fourth consultant and the creation of a fourth sector team. Additionally, one of the existing Louth sectors also served part of Meath; this sector should be redefined to be contiguous with County Louth only. The Inspectorate reiterated its view that the Louth and Meath services should be independent and autonomous, other than for some specialised services which could be provided on a joint basis for both counties or on a North-Eastern regional basis.

The objective of providing mental health centres/day hospitals for the three catchment area sectors — Dundalk, Ardee and Drogheda — made some progress since the previous inspection, although much more remained to be done. The day centre/day hospital (Ladywell) premises in Dundalk at the County Hospital had been extended and active discussions had taken place between administrators and clinicians in Our Lady of Lourdes Hospital, Drogheda to make mental health services more readily available in that hospital. However, there was still only an embryonic day hospital in the Dundalk sector and no day hospital in either the Ardee or Drogheda sectors. The consequence was that patient assessment, apart from that performed at weekly or fortnightly out-patient clinics, was carried out in the admission unit at St Brigid's Hospital. This reduced the possibility of alternatives to hospitalisation.

A new sixteen-place high-support residence was to open within six weeks of the inspection on the Ladywell campus, Dundalk adjacent to the existing mental health facilities on the campus. It was anticipated that the residence would accommodate some long-stay (including intellectually disabled) patients from St Brigid's Hospital and four older patients from the Point Road residence in Dundalk. This would free up places at Point Road for in-patients from St Brigid's. Santa Barbara, the former nurses' residence in Ardee, was to be refurbished and extended to provide an eight-place intensive care unit for the North-Eastern region. Clinical administrative arrangements for running the unit had to be worked out but it was suggested that one of the Louth consultants would attend the unit on a part-time basis. Cox's Demesne, which has been criticised by the Inspectorate in the past because it required extensive refurbishment, had closed. The Board had made no plans to dispose of it and it could be refurbished for future residential use. It was disappointing that no planning or design team had been set up to work on the brief for the new acute psychiatric unit at the Louth County Hospital, Dundalk. Given that this project was to be completed by 2004, it was felt that work on the unit needed to begin. It was all the more important in view of the deficiencies of the existing admission unit in St Brigid's Hospital, Ardee.

St Brigid's had reduced to four wards; an admission unit and three long-stay units. Some of the vacant space in St Brigid's was being used by the North-Eastern Health Board Health Education Programme. As a result, the occupational/activation department had relocated from an attractive and appropriate building on the hospital grounds to a vacant

space in the main hospital building at the former Oriel Ward. This was done to make room for a nurse education centre. While the need for accommodation for the educational programme was acknowledged, it was regrettable that this relocation had taken place: first, because the building was more suited for occupational therapy than the area provided in the hospital and, second, the concept of bringing psychiatric activity back into St Brigid's was unsound.

The majority of patients in the three long-stay wards of St Brigid's Hospital were older persons. It was felt their future care would be best served by de-designation and integration into a county-wide programme for the care of older persons. In this regard, the Louth Mental Health service intended creating a consultant-led team for the care of older persons, similar to that to be put in place in the Meath Mental Health service. Twenty patients in St Brigid's Hospital were patients with an intellectual disability. Five were to be taken into the care of the intellectual disability services at Drumcar shortly after the inspection, some were to move to specialised facilities in County Monaghan and others were to relocate to community residences in County Louth. Further transfers to other residential accommodation and the transfer of admission facilities to the Louth County Hospital, Dundalk in approximately 2004 would mean St Brigid's Hospital could close. Only the Santa Barbara psychiatric intensive care unit would remain a part of the in-patient mental health service for the Ardee sector.

The admission unit at St Brigid's was unsatisfactory; the layout and general spatial arrangements were unfavourable. The unit was locked at all times which was unfortunate. Staff in the unit were convinced there was a high level of disturbance among patients in the service. This belief could stem from the fact that they had to deal with disturbed adolescents in the recent past. Child psychiatric services for the county lacked in-patient accommodation for children and adolescents and the residence adjacent to St Brigid's Hospital grounds would probably continue to be used by them. This residence was forfeited by the adult service in 2000 for this purpose. No psychologists, social workers or occupational therapists were employed in the Louth Mental Health service despite the establishment of posts as it was impossible to fill them and thus impossible to create true multidisciplinary teams.

Useful initiatives on the nursing scene had taken place in Dundalk. Two nurses had been allocated to a special treatment programme which essentially meant that they were strengthening inputs for persons with affective disorders and including a home-care component; a similar initiative was anticipated in relation to schizophrenia. Additionally, a nurse was delegated to work with the Louth County Hospital on identifying and following-up of patients following attempted suicide. An audit initiative in relation to patients coming into the admission unit was completed shortly before the inspection. The results had been published in booklet form and were available to those interested.

Ninety-eight patients were in St Brigid's Hospital on the day of inspection. Nine were temporary, one was a PUM and nine were Wards of Court. Sixteen patients were prescribed ECT in 2000 and the documentary procedures relating to ECT were satisfactory. A written policy on the administration of ECT and pre- and post-ECT procedures were

documented for staff reference. Nursing checklists were appropriately recorded. A new policy relating to a nurse's responsibility in preparing a patient for ECT, pre- and post-ECT care and checking the ECT suite was included in the nursing policy/procedure manual available in each ward.

There were 220 episodes of special one-to-one nursing supervision involving four patients in 2000. Revised policy and procedures relating to special nursing observation were available in each clinical area. These included a definition of special nursing observation and set out the procedure to be followed once special nursing was prescribed. Records were kept of nurses carrying out special nursing observation and they were completed at each hand-over. One patient was on special nursing supervision at the time of inspection and the local policy and procedure was being followed. It was suggested that written records be maintained by the observing nurse on completion of the period of duty. It was noted that special nursing supervision appeared to be rotated amongst staff every two hours where possible, with an appropriate hand-over period to discuss and evaluate the patient's care. This was satisfactory. Seclusion was not used in the service.

Eleven patients had their temporary orders extended during 2000 and forty-two patients discharged themselves from the hospital against medical advice. Thirty-four accidents to patients and six accidents to staff and twenty-one assaults on patients by other patients and nineteen assaults on staff were recorded during 2000. None of the accidents were deemed serious, while one patient and four staff assaults required further medical intervention. A regional complaints procedure was in place. It set out the objectives of the complaints policy, the names of complaints officers, how to make a complaint and what to do if the complainant was dissatisfied with the response. It was printed in 1999 and was widely available in all in-patient care areas. Information on the appeal procedure for involuntary patients was on public display in the in-patient care areas. All of this was satisfactory.

A revised nursing policy on the administration of medicines in hospital and in the community was available. The content related mainly to procedural issues in respect of storing and administering medicinal products. A number of prescription cards and nurse administration recording cards were examined. The legibility of individual prescriptions was reasonably satisfactory. Some prescriptions were written in block letters with a low risk factor for drug error while others were scripted but were not difficult to read. All prescriptions should be signed and dated individually. Overall standards varied. There was provision for recording drug allergies and this information was readily available to staff. Discontinued drugs should be signed off using the discontinuation column; there was an increased risk factor if discontinued prescriptions exceeded the number of current prescriptions. This was noted in a small number of prescriptions examined. The signature of the prescriber was illegible in some instances and there was a need to provide for the nurse's full signature on the drug recording card. A tendency for some prescribers to record the day and the month but not the year was noted on some prescriptions. The full date should be recorded on each individual prescription card.

Case note structure and layout in St Brigid's needed to be revised if not fundamentally re-ordered. The quality of patient admission documentation kept by the medical staff was

unsatisfactory and needed to be more extensive, rigorous and disciplined. Case notes lacked details of care programming for patients. A number of nursing records were examined. The 'Roper Model' of nursing, involving an appropriate care planning system, was used throughout the hospital. Care plans included an assessment and appropriate goal setting and were reviewed each week (more often in the acute wards). Records were generally written clearly and were dated accurately. It was suggested that the time of entry of all reports, particularly the night report, should be recorded and the system of using 'nocte' discontinued. New patient weight charts and a new pressure sore prevention, risk assessment and protection chart were incorporated into the nurse care planning system in the long-stay areas. All of this was satisfactory. The impressive discharge checklist used by the nursing staff was completed satisfactorily. Overall, standards were satisfactory but it was felt that the records should reflect in greater detail the involvement of patients in planning and making decisions about their own care and treatment. Entries should include patients' wishes, preferences and suggestions about treatment approaches. Similarly, evaluations of nurse care plans should include patients' views about progress, any negotiated changes in the plans and the result of such changes.

A number of clinical files were examined and, again, overall standards varied. Admission notes in files examined in the admission unit were generally satisfactory. Pathways to admission, history of presenting complaint, past personal and family history, current medication, mental state examination, physical examination and clear immediate management plan were all well documented. Clinical progress notes provided a chronological account of the illness. Investigation reports were filed correctly and correspondence was filed in chronological order. File covers were generally in good condition, but there was a considerable amount of loose clinical material in the back of some files. Records of physical examinations of patients in the long-stay wards were appropriately entered. Written instructions on filing documentation within the records should be considered. Some notes, particularly in some long-stay areas, were difficult to follow and difficult to read. Whilst the date of each entry was appropriately recorded, the time of entry should also be recorded. Space to record the patient's name was provided on each continuation page but this was not recorded in many of the notes examined. A discharge note was sent to the GP on the day of discharge. It contained information on diagnosis, medication on discharge, a summary of all relevant information and follow-up arrangements. One copy was sent to the GP, one to the community psychiatric nurse and one was retained in the patient's file.

The extension of temporary patient reception orders was recorded in case notes but not the reason for it. The key-worker approach operated with acute patients and seemed to work well, although one patient interviewed indicated that he did not know that a key worker had been assigned to him nor who that person was. Progress reappraisal and clinical goal-setting for long-stay patients did not appear to take place and the team meetings which characterised the care of acute patients did not feature with long-stay patients as far as could be ascertained. In this regard, it was felt important that a consultant team should be given responsibility for rehabilitation. Some of the long-stay in-patient settings in St Brigid's needed to be redecorated and refurbished.

There was a written safety statement for the hospital and all local units which adhered to the standards and procedures set by the Safety and Welfare at Work Act, 1989. Department safety statements were available at each location and included copies of hazard identification and control sheets and action taken. There was a system in place where staff confirmed by signature that they had read and understood the hospital and department safety statement and safe work-practice sheets for the ward. Similarly, each new policy manual had a leaflet for staff to confirm they had read and understood the policies and procedures. There was a need to ensure that all staff reading this documentation signed this form.

The integrated clinical audit report of admissions and assessment practices in the admission unit was impressive. This report was a follow-on to a similar report at the Department of Psychiatry, Navan General Hospital and was a response to the Guidelines on Good Practice and Quality Assurance in the Mental Health Services issued by the Department of Health and Children in 1998. A range of issues relating to examining policy and admission procedures, examining the information booklet, interviews with patients and relatives and examining medical and nursing notes was assessed during the audit period. A summary of the findings was published for staff information. The audit identified strengths and weaknesses in service provision and staff were proactive in ensuring that patients' wishes were adequately catered for. It was hoped that this very welcome initiative would be repeated.

A number of patients in the admission unit were interviewed in order to determine their level of satisfaction with the care provided. Patients were satisfied with the courtesy and helpfulness of staff, were introduced to the professional team responsible for their care, knew the name of their consultant psychiatrists and had adequate access to them whilst hospitalised. Patients said they would like more information on their rights under the Mental Treatment Act, 1945 and on how to make a complaint if they felt aggrieved. It was pointed out that the patients' rights notice was prominently displayed in each ward and there was a comprehensive complaints procedure. Patients indicated that they would like staff to bring these matters to their attention. One patient indicated that he had not been informed about the nature of his medical condition, nor about his medication and treatment. He did, however, emphasise that he was not in 'good shape' on admission, was only in hospital one week and assumed he would be informed in due course. Patients were generally satisfied with aspects of privacy and dignity relating to their care and with the cleanliness and hygiene of toilets and bathrooms. They reported that it was possible to have a bath or shower as required or within a reasonable time of asking. However, one male patient complained that the shower unit was not working for the entire week prior to inspection and there was no indication as to when it would be repaired. All reported that the sleeping arrangements in the unit were adequate and that it was possible to get a good night's sleep.

All patients felt there was adequate respect for privacy when being given information about treatment or advice. They described the ward environment as safe and reassuring and the ward decor as average. All patients had been offered access to the occupational therapy department. One patient declined to participate and the others found it useful. The patients interviewed had adequate contact with members of the nursing staff whilst

hospitalised. Two patients were aware of the primary nursing system but did not know the name of their primary nurse which indicated a need for primary nurses to introduce themselves to the patients at the start of each nursing shift. One patient was not aware of the primary nursing system. While one patient had no problems with the idea of a locked door, other patients would prefer the door to be open. All patients reported being actively involved in decisions affecting their care. Patients reported being satisfied with the information given to them about prescribed medication and its long- and short-term effects. When asked if they would like written information on prescribed medication, they replied that written information was not necessary. Patients interviewed who were previously hospitalised in St Brigid's reported on the improved physical conditions and improved catering arrangements.

RECOMMENDATIONS

It is recommended that:—

1. A planning/design team be set up immediately to work towards putting the acute unit at the Louth County Hospital in place as soon as possible.
2. A comprehensive day hospital/sector headquarters/community mental health centre be established in all three sectors.
3. Renewed efforts be undertaken to recruit social workers, psychologists and occupational therapists so that multidisciplinary team working can be put in place.
4. A dedicated smoking area be provided at St Brigid's day centre, Drogheda.
5. Upgrading of wards in St Brigid's Hospital continues.

MEATH MENTAL HEALTH SERVICE — 2001 INSPECTION

INSPECTED ON 28 AUGUST, 2001

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 90,893 was divided into three sectors as follows:—

Sector	Population
Navan	26,134
Dunshaughlin	27,295
Trim/Kells	37,464

IN-PATIENT CARE

In-patient care was provided at the Department of Psychiatry, Our Lady's Hospital, Navan where twenty-six beds were provided in one integrated unit.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	2	9	6	1	—	18	100
3-12 Months	—	—	—	—	—	—	—	—
1-5 Years	—	—	—	—	—	—	—	—
> 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	2	9	6	1	—	18	100
% of Total	—	11.11	50.00	33.33	5.56	—	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	3	5	8	1	1
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
—	—	—	—	—	18

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	5	10	15
Temporary	1	2	3
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	6	12	18

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 280
Number of first admissions in 2000 67
Number of discharges in 2000 266
Number of deaths in 2000 2

Legal status of admissions
Voluntary 85.7%
Non-voluntary 14.3%

The number of admissions represented an admission rate of 3.1 per 1,000 of the catchment population. First admissions accounted for twenty-four per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	—	—	—
Day Centres	3	59	87
Out-patient clinics	4	217*	769

*No. of out-patient clinics held in 2000

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
—	—	1	6	1	12

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
10*	19*	147*	56*	9.2*

*Staffing and budget included in overall figure for Louth Meath Mental Health Services.

COST

The budget for the Meath Mental Health Service was £8.16 (€10 .3) million in 2000.

GENERAL COMMENTS

The County Meath mental health service should be autonomous and independent clinically and administratively from the County Louth service. Both the size and geography of the catchment area justified an independent service. A compelling argument for the separation was the fact that one of the County Meath sector teams had responsibility for long-stay patients in St Brigid's Hospital, Ardee and it was difficult to see how this responsibility could be adequately discharged from a County Meath-based sector. In addition, East Meath formed part of the Mid-Louth/East Meath sector in the Louth Mental Health service. This was unsatisfactory and the Inspectorate would like to see the entire County of Meath included in the Meath Mental Health service.

All three sectors in the Meath Mental Health service needed major infrastructural development; sector headquarters, day hospital/community mental health centres and community residences (particularly high-support residences) were required. The Dunshaughlin day centre, although ideally situated in a new health centre premises, was very limited and only catered for approximately seven or eight patients each day. There was adequate land on the site to build an extensive day hospital/community mental health centre. It was hoped that the commitment and capital resources necessary would be forthcoming. The day hospital in Clonard House, although ideally situated in the centre of Navan, was physically limited in its capacity to cater for disturbed patients and therefore the range of illnesses it could cope with. The Táin day centre in Navan provided adequate space for a range of activities, catered for a substantial number of patients and fulfilled a very useful function. However, the North Eastern Health Board planned to close the entire building and build a replacement facility on a green-field site which would also provide day and residential care for older persons. It was felt that the new premises for mental health services at this site, if extended, would provide an excellent day hospital if the Táin centre remained at its current location. It was unclear whether structural or other difficulties with the infirmary building where the Táin day centre was based made its vacation essential.

A day centre had opened in the centre of Kells in 2000. While it was a very useful initiative, the house in which the centre was located was small and limited the number of persons who could attend. A large, centrally-located building to provide a comprehensive day hospital and sector headquarters was urgently required. Plans to provide further day facilities for the Trim/Kells sector in Trim were at an early stage. There were only two community residences, one medium-support and one high-support, in the entire Meath Mental Health service. It was imperative that this deficit be remedied without delay as the twenty-six bed psychiatric unit in Navan General Hospital had become overburdened in 2000 as a result of the lack of alternative residential accommodation. There were thirteen episodes of patients from the Meath service being admitted to St Brigid's Hospital in 2000 because no beds were available in the unit in Navan. It was reported that capital funds were available to purchase premises for community residential accommodation and premises had been identified, particularly in Kells. However, the Board appeared to have withdrawn from the initiative as a result of local community opposition. The Inspectorate urged that efforts be continued to reach agreement as additional community residences were essential for the service.

The in-patient unit at Out Lady's Hospital, Navan was pleasant and attractive but it suffered from a lack of space for occupational and recreational activities. Neither an occupational therapy department nor an occupational therapist were in situ. This deficit was highlighted by some of the patients interviewed who felt that the days in the unit could be long and boring because there was 'nothing to do'. It was understood that the Board had attempted to recruit additional occupational therapy staff, as well as psychologists and social workers, to put in place two multidisciplinary teams, but found it difficult to fill the posts. Staff in the Meath Mental Health service felt that a specialised service for the psychiatry of later life was needed and pointed out that the Louth service, with a similar catchment area population, had already established such a post. If this service was put in place, then some of the beds in the acute unit would be needed for this speciality and it would put further strain on in-patient capacity and highlight again the need for increased community residential accommodation.

An inspection of documentary procedures in the acute unit highlighted some concerns relating to case note structure and the entering and recording of notes. Similar comments applied to written procedures on seclusion. The case note documentation of admission assessments and care programme arrangements needed to be improved; this was equally true of diagnostic formulations and, particularly, the entry of ICD diagnostic codes. A high level of special one-to-one nursing supervision was noted. In the unit, as elsewhere in the service, it was noted that few staff wore identification badges. ECT treatment was administered in the unit and the previous practice whereby patients had to be transferred to St Brigid's Hospital for this purpose had stopped. The process was quite satisfactory; anaesthetists were available and the treatment was given early in the morning.

Patients interviewed in the unit were generally satisfied with their care and treatment. Apart from one patient who said that he had seen three different consultants since admission and did not know the name of his current one, the others knew their consultants and had ready access to them. All indicated that their treatments were explained to them,

including their side-effects. They were satisfied with the meals served, with the decor and furnishings, and with the bathroom and sleeping arrangements. Overall, apart from complaints of boredom, patients were generally satisfied with their experiences in the unit.

RECOMMENDATIONS

It is recommended that:

1. The Meath Mental Health service become completely autonomous and independent from the Louth Mental Health service.
2. Community residential accommodation in the catchment area be increased as a matter of urgency.
3. Appropriate provision be made for comprehensive day hospital facilities in all three sectors.
4. Renewed efforts be made to recruit social workers, psychologists and occupational therapists to enable multidisciplinary sector-based activities to occur.

CHAPTER SIX

North-Western Health Board

DONEGAL MENTAL HEALTH SERVICE — 2001 INSPECTION

INSPECTED ON 29 MAY, 2001

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 121,412 was divided into six sectors as follows:—

Sector	Population
Donegal Central	20,950
North Central	14,611
South Central	18,897
Donegal South West	17,064
Donegal North West	22,945
Donegal North East	26,945

IN-PATIENT CARE

In-patient care was provided at the fifty-six bed acute psychiatric unit, Letterkenny General Hospital and St Conal's Hospital which provided forty-two beds in one male and one female unit.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	20	13	4	4	41	48.23
3-12 Months	—	—	6	1	1	—	8	9.41
1-5 Years	—	—	3	14	1	—	18	21.18
> 5 Years	—	—	1	14	3	—	18	21.18
All Lengths of Stay	—	—	30	42	9	4	85	100
% of Total	—	—	35.29	49.41	10.59	4.71	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
1	30	1	19	10	3
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
2	13	—	6	—	85

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	44	18	62
Temporary	10	8	21*
P.U.M.	1	1	2
Ward of Court	—	—	—
Total	55	27	82

*Three patients from the Donegal service were patients in the special care unit in Sligo

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 803
Number of first admissions in 2000 211
Number of discharges in 2000 832
Number of deaths in 2000 4

Legal status of admissions
Voluntary 89.3%
Non-voluntary 10.7%

The number of admissions represented an admission rate of 6.6 per 1,000 of the catchment population. First admissions accounted for twenty-six per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	20	134
Day Centres	7	194	301
Out-patient clinics	15	556*	1,427

*No. of out-patient clinics held in 2000

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
12	60	—	—	4	67

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
12.5	13	173.5	74.3	6.2

COST

The cost of the Donegal Mental Health Service was £10 (€12.7) million in 2000.

GENERAL COMMENTS

Significant progress had been made in recent years towards the provision of community facilities. The mental health centre in the former RMS residence became fully operational last year and provided a sector headquarters and day hospital with a full programme of

therapeutic activities. This modern unit provided twenty day places for persons suffering from acute mental health conditions as an alternative to in-patient care. An intensive out-patient service was provided five days per week with a reduced service at weekends. The service operated under the general direction of a consultant psychiatrist and was staffed by five full-time nurses. It also employed a generic nurse counsellor which enabled the service to operate to full capacity. Multidisciplinary teams for the three sectors involved needed to be substantially strengthened and the service providers acknowledged this need. For example, there was only one psychiatric social worker employed in the Donegal service. There were no occupational therapists in spite of repeated attempts by the health board to recruit these grades and the psychology service was provided on a sessional basis from community care. The day hospital in Dungloe was upgraded and refurbished during the year.

Two new supervised residential units in Carndonagh and Letterkenny opened in 2000. They provided forty additional beds in community settings and facilitated the closure of St Eunan's Ward in St Conal's Hospital. Safety statements were available at both locations and staff had established fire safety drills for residents and appropriate records were kept. The residents in both units were settling down and were integrating well into the local communities. Twelve residents moved into new supervised residential accommodation in Dungloe which had been purchased by the Board at a cost of £350,000 (€444,400). The accommodation was formerly a large bed and breakfast and comprised two buildings. The front building had eleven beds and was being used as a supervised residential unit. A further thirteen beds in the extension to the rear of the building was to become available to the service in the months following the inspection and it was hoped that a twenty-bed supervised residence unit would be fully operational in the autumn of 2001.

A new consultant psychiatrist had been appointed to the Donegal North East Sector. This consultant provided a community service in the Inishowen Pensinula and was based at the supervised residential unit in Carndonagh which also incorporated a day centre facility and the day centre services in Buncrana. The remainder of the service comprised out-patient consultations and home care nursing. Patients admitted from this sector to Letterkenny General Hospital were treated by other consultants of the Donegal Mental Health Service. The day centre at St Conal's Hospital had relocated from its ground floor location to the second floor to make way for the relocation of the de-designated St Agnes's Ward. The present location was not ideal and it was recommended that the day centre move to a location away from the hospital campus.

St Agnes's Ward in St Conal's Hospital had relocated to the ground floor of the hospital to provide space for the development of a new geriatric rehabilitation facility. The number of beds in the ward had reduced to seventeen with the transfer of five older persons to an external nursing unit. In addition to the de-designated St Agnes's Ward, there were two continuing care wards — St Kieran's and St Bernadette's — with a total of thirty-four patients. Most of these patients were long-stay patients and some had seriously disabling mental illness which would require substantial rehabilitation inputs if they were to be reintegrated into the community. The service was looking at various options for the appropriate future care of these patients. One option was to purchase a large private nursing

home in the Letterkenny area. A considerable number of patients in both wards would be suitable for placement in a supervised residential unit but some would require intensive rehabilitation inputs prior to any decision to place them in a community setting.

The Mount Southwell Social Club located at Market Square, Letterkenny opened on 1 February, 2001. It was a social group and meeting point for discharged patients of the Donegal Mental Health Service. The club, a drop-in centre, opened each Wednesday from 8 p.m. — 10 p.m. and the attendees had been involved in decorating and upgrading the premises. This was a voluntary initiative supported by the People in Need Trust, local councillors, local business people, the North Western Health Board and the Donegal Mental Health Service. This was a very worthwhile and exciting development and the Inspectorate looked forward to evaluating its effectiveness in the years ahead.

Eight patients from the Donegal Mental Health Service were in the special care unit in Ballytivnan, Co Sligo on the day of inspection. Serious attempts must be made to repatriate all of the long-stay patients in this unit back to the Donegal service. Donegal patients who were in the special care unit in Sligo for a long time were isolated from their families and considerable distances were involved for families travelling to Sligo from some parts of Donegal. While the relocation of patients from the two existing wards in St Conal's to supervised residential units was supported, it was suggested that one ward be retained in the short term to facilitate the repatriation of patients from the special care unit in Sligo. This should be given priority consideration. The service should also consider providing a training residence for young adults, as some patients were refusing to come to hospital due to the mix of patients.

There were long-term plans to re-develop the acute admission unit at Letterkenny General Hospital and it was understood that funding had been made available for the refurbishment and re-development programme. Additional facilities such as a mother and baby unit, a high observation unit, additional office space and improved ECT facilities were all required. The number of beds in the unit had reduced from fifty-eight to fifty-six to facilitate the provision of a recovery area at the ECT suite. This was the only change that had taken place in the unit since the previous inspection. The unit itself needed to be extensively refurbished if it was to continue to carry out its designated function appropriately. There was considerable overcrowding in the bed areas and day space was restricted. A considerable number of patients, both male and female, were confined to the ward areas on bed rest due to the inadequate facilities in the unit. In addition, there were no admission or assessment beds for the newly established psychiatry of later life service. Valuable space was being used for out-patient consultations but psychiatric out-patients should attend the out-patient department of the general hospital. A project team had been appointed to examine the feasibility of upgrading or designing a new unit at Letterkenny General Hospital. Service providers favoured the provision of a purpose-built unit on the existing site with the relocation of the patients in the acute unit to the vacated wards at St Conal's during the demolition and construction phase. No decision had been made at the time of inspection as various options were under active consideration.

Two training units located in Letterkenny were not operating at full capacity. There was a proposal to amalgamate both units which would free up one of the units for use as a

day centre. It would then be possible to relocate the day centre and the two occupational therapy departments in St Conal's Hospital to this upgraded facility.

A new consultant psychiatrist post in learning disability had been established in the Donegal Mental Health Service since the previous inspection. The consultant was working within the community care component of the service and had access to beds other than psychiatric beds. There were eight patients with a learning disability in St Kieran's Unit at St Conal's Hospital and three in the acute unit. The learning disability consultant needed to assess these patients with a view to their long-term placement. The new post of consultant psychiatrist in later life psychiatry had not been filled at the time of inspection. Interviews had been held but the successful candidate subsequently declined the post and the position was to be re-advertised. Six/eight beds in the acute unit needed to be provided for this new and developing service. The appointment of additional paramedical staff, including an enhanced occupational therapy service and the strengthening of community rehabilitation and therapy units, was required.

There were 661 spans of special nursing supervision involving thirty-one patients in the Donegal service last year. A policy and procedure on the levels of nursing observation was available in each clinical area. Seclusion was not used in the service. Thirty-one patients were prescribed ECT in 2000. Documentary procedures relating to ECT were satisfactory but the facilities at the acute unit, Letterkenny General Hospital required improvement. Seventy-six patients discharged themselves against medical advice last year but the procedures for follow-up of such patients were appropriate. There were four recorded complaints/appeals by patients and relatives of patients to the local complaints/appeals manager during 2000 and all appeared to have been dealt with satisfactorily. Thirty-five accidents to patients and two accidents to staff and twenty-one assaults on patients by other patients and forty-five assaults on staff were recorded. Five assaults required further medical intervention. Detailed auditable criteria on assaults and accidents/incidents were maintained and this was satisfactory.

A number of clinical records in the admission unit were examined. Written instructions on the filing of documentation within the records was available. The first admission note on all patients was typed and it set out pathways to admission, history of presenting complaint, past history, personal history, family history, current medication, mental state examination and physical examination. This was all satisfactory. A clear immediate management plan and summary should be documented. Some of the subsequent notes on some of the files were difficult to read and therefore difficult to follow. While space was provided to record a patient's name on each continuation page, this was not always done. The date of input was clearly recorded and it was suggested that the time of input should be recorded and all entries signed in full. A discharge note was sent to the patient's GP on the day of discharge and discharge letters were typed within a reasonable timeframe. Copies of the discharge letters were easily accessed on the file and contained prognosis, follow-up arrangements, summary of relevant information, medication on discharge and diagnosis. This was satisfactory. Investigation reports were correctly filed, correspondence was in chronological order and the file covers were in good condition. There was considerable loose clinical material in the back of a number of files. It was suggested that this material be made an integral part of the file.

There was a written drugs policy and procedure which was last updated in 1999. Generally speaking, individual prescriptions were kept up-to-date, were signed and dated individually and were legible. Changes in prescriptions were written as new prescriptions and drug allergies were recorded. Prescribed medication was also recorded in patients' case notes. Information on medication was given to patients before they started treatment and consideration should be given to providing written information to patients on their medication, treatment and any alterations so that an informed choice can be made and recorded in the notes. One case inspected had a greater number of discontinued prescriptions than current prescriptions and this should be rewritten as it resulted in an increased risk for errors. Discontinued drugs were not always signed off using the discontinuation column.

The 'Orem model' of nursing was used in the Donegal service and there had been appropriate staff training on the nurse care planning system before this model was introduced. The records examined identified problems and action taken to rectify them. Records were clearly written and accurately dated. Patients' names were recorded on each continuation page. It was suggested that the nursing record be audited to assess the standards of the records and to identify areas for improvement and staff development. Ideally, records should reflect the involvement of patients in planning and making choices and decisions about their care and treatment and the evaluation of nursing care plans should include patients' views about their progress, any negotiated changes in the care plans and the results of any changes.

A number of patients in the acute admission unit were asked for their views of the level of service provided. It was envisaged this might highlight areas where the local service needed to make changes and respond to patients' wishes. Patients were asked about issues such as the quality of information provided to them, aspects of their care and the courtesy and helpfulness of staff. Patients were generally satisfied with the courtesy and helpfulness of staff, knew the name of their consultant psychiatrist and had daily access to their psychiatrist whilst hospitalised. Patients were informed about the nature of their medical condition, including medication and treatment, and understood what was explained to them. All of the patients interviewed were aware of their legal status whilst hospitalised. They were satisfied with the quality and quantity of food and with the cleanliness of the toilets and bathrooms. One patient complained about the sleeping arrangements which were particularly noisy at night. Patients reported having adequate storage space for clothing and personal belongings and adequate facilities to wash personal clothing. One patient felt that the ward decor was only average, although better than it used to be. Patients were aware of the primary nursing system and felt they had adequate contact with nursing staff. Some patients in particular liked the fact that student nurses chatted with them while other staff who may be busier also seemed to have time to chat with patients.

Patients complained that the day was long and boring especially in the afternoons and reported that there were adequate activities once they were given their clothes and no longer confined to bed rest. One patient reported a lack of privacy when being given treatment or advice in the bedroom areas as other patients could overhear what was being discussed. Patients reported free access to public phones once they were taken off bed rest and were allowed one phone call per day while on bed rest. When asked what patients

thought should be done to improve their stay in hospital, all of the patients complained about smoking in the bedroom areas and the need to enforce a smoking policy. One patient complained that the lunch at 11.45 a.m. was too early and that there was a long break until 4.45 p.m. for the evening tea. Mealtimes needed to be reviewed. All of the patients reported active involvement about decisions affecting their care. Three patients in St Conal's Hospital complained about inadequate access to their consultant psychiatrist. One patient requested access to a time-out room as the ward was too noisy.

RECOMMENDATIONS

It is recommended that:—

1. The acute psychiatric unit at Letterkenny be remodelled and refurbished or replaced.
2. The day centre be relocated from the first floor of St Conal's Hospital to a centre in Letterkenny town.
3. Appropriate rehabilitation inputs be provided to in-patients in St Kieran's and St Bernadette's wards to facilitate their placement in community residences.
4. Efforts be made to return long-stay Donegal patients in the special care unit in Sligo to the Donegal service.
5. A smoking policy be introduced in the sleeping areas of the acute unit, Letterkenny General Hospital.
6. Patients with intellectual disabilities in St Conal's be assessed by the new consultant psychiatrist with responsibility for learning disabilities with a view to recommending suitable placements.
7. Psychiatric out-patients be moved from the acute unit to the out-patient department at Letterkenny General Hospital.

SLIGO/LEITRIM MENTAL HEALTH SERVICE — 2001 INSPECTION

INSPECTED ON 30 MAY, 2001

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 92,000 was divided into four sectors as follows:—

Sector	Population
West & South Sligo	20,292
South Leitrim	16,630
North Sligo/North Leitrim/South Donegal	26,245
Sligo City	27,133
West Cavan assimilated to Leitrim Sectors	1,700

IN-PATIENT CARE

In-patient care was provided at Ballytivnan, Sligo where sixty beds were provided in one male, one female and one integrated ward.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	18	15	4	1	38	67.86
3-12 Months	—	—	4	5	—	—	9	16.07
1-5 Years	—	—	2	2	—	—	4	7.14
> 5 Years	—	—	1	4	—	—	5	8.93
All Lengths of Stay	—	—	25	26	4	1	56	100
% of Total	—	—	44.64	46.43	7.14	1.79	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	24	—	11	6	6
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
4	3	—	2	—	56

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	23	15	38
Temporary	9	6	15
P.U.M.	1	2	3
Ward of Court	—	—	—
Total	33	23	56

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 574
Number of first admissions in 2000 64
Number of discharges in 2000 563
Number of deaths in 2000 2

Legal status of admissions
Voluntary 85.2%
Non-voluntary 14.8%

The number of admissions represented an admission rate of 6.2 per 1,000 of the catchment population. First admissions accounted for eleven per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	4	98	285
Day Centres	5	80	84
Out-patient clinics	12	312*	Not specified

*No. of out-patient clinics held in 2000

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
15	63	1	6	8	103

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
9	16	242	31.5	10

COST

The budget for the Sligo/Leitrim Mental Health Service was £10.7 (€13.6) million in 2000.

RECOMMENDATIONS

The Sligo Mental Health Service has undergone major changes over the past decade. In-patient numbers have reduced from 217 in 1991 to fifty-three on the day of inspection. Considerable infrastrucutal developments within the Sligo/Leitrim, South Donegal and West Cavan catchment areas had facilitated these major and significant changes which had brought about improved service provision closer to patients' homes and enhanced alternative residential accommodation. One hundred and seventy-two former patients of St Columba's Hospital were now accommodated in alternative residential facilities throughout the catchment area. Accommodation in all of the community residences was of good quality, comfortable and well designed with furnishings and decor to meet the needs of the residents. A considerable amount of work and effort on the part of the Board's staff and the service providers went into purchasing and commissioning the twenty-five community residences, all of which have been inspected over the past two years. All of them were well maintained and adequate security to protect the properties was provided. The residences also had automatic fire detection systems. Meals were varied, well presented and provided at flexible hours.

The supervised residence at Sliabhban, Sligo which opened in May, 1999 was particularly impressive. Many of the patients who moved to this location had been chronically institutionalised in St Columba's Hospital. Improved facilities and support from staff have ensured they have settled well into the new environment which, like some of the other

houses in the service, was of exceptional quality. Patients had improved considerably in this new environment and a new activity centre was under construction to engage patients in various forms of recreational, social and occupational activities as many were unable to utilise existing facilities in the service due to age, infirmity or difficulty with travel. The purchase of a new high-quality supervised residence in Manorhamilton was also welcomed. This new facility was being refurbished at the time of the inspection and, once completed, would facilitate the transfer of residents in the Bank House residence to this new residence. Bank House was also located in Manorhamilton and it was to be redecorated and utilised as a low-support residence.

Plans to replace the existing admission facilities at Ballytivnan, Sligo with a new acute admission unit at Sligo General Hospital were at an advanced stage. A site on the general hospital campus had been identified and the project had moved to phase II of the Sligo General Hospital development plan. Plans to evacuate the existing site were in place and the project team was preparing for full planning permission for the new unit. It was expected that the unit would be commissioned within two years. There were plans to develop a psychiatry of later life service within the catchment area and it was expected that a later life consultant psychiatrist would be appointed in August, 2001. There were plans to allocate four beds at the acute unit, Sligo General Hospital to this service. As there were plans to develop consultant psychiatrist posts in rehabilitation psychiatry and learning disabilities in the Donegal service, the need for developing such services in the Sligo/Leitrim service should be examined.

Two social workers were employed in the Sligo/Leitrim Mental Health service and the level of service provided was satisfactory. While there was approval for three occupational therapy positions, no occupational therapist was employed, despite repeated efforts by the Board to fill existing vacancies. Psychological services were provided on a sessional basis from community care. The service had four alcoholism counsellors, four behavioural nurse therapists and two family therapists, all of whom were providing a satisfactory service.

With the relocation of the admission facilities to Sligo General Hospital, the only in-patient component that would remain on the Ballytivnan site would be the intensive care unit. This unit has been extensively refurbished and redecorated in the past eighteen months and provided intensive care for persons with disturbed or challenging behaviour. There were twenty-eight admissions to the unit from the Sligo/Leitrim service in 2000. Eight were direct admissions to the unit, two were transfers from Sligo General Hospital and eighteen were transfers from the admission unit at Ballytivnan. A further nine patients were transferred from Letterkenny General Hospital. The unit accommodated eleven patients on the day of inspection and eight were from Donegal. Serious efforts should be made to repatriate the long-stay patients from the intensive care unit to appropriate facilities in the Donegal Mental Health services. The number of beds in the intensive care unit had reduced in recent years and a staff of nine nurses during the day and four night nurses was generous.

There was a need to ensure a therapeutic milieu continued to operate in this unit and that custodial approaches to care, which could easily creep into such an environment, were

kept under constant review. There had been thirty-eight episodes of seclusion involving five patients in the unit since 1 January, 2001. The local seclusion policy and procedure was last reviewed in May, 2000. Some information on time-out, which was often used synonymously with seclusion although it was an entirely different approach to care, needed to be included when the policy was next reviewed. Medical notes relating to seclusion episodes indicated a medical assessment was conducted prior to each seclusion episode. Patients were reviewed each day while in seclusion and were reviewed following each seclusion episode. This was satisfactory. There was evidence that patients were smoking in the seclusion room and this should be discouraged.

A total of five day centres and four day hospitals were provided by the service and there were plans to improve day service facilities with developments in Manorhamilton, Easkey, Ballymote and Carrick-on-Shannon. Service providers felt that the current premises in Carrick-on-Shannon were inadequate due to its poor condition and intrinsic layout. As mentioned in previous reports, the Inspectorate agreed that new green field development on St Patrick's Hospital site to provide a sector headquarters and day hospital was necessary. The redecoration and refurbishment of the existing premises at Carrick-on-Shannon was welcomed. The Inspectorate also welcomed plans to build a new primary health-care centre with accommodation for eleven Sligo-based GPs and complementary community-based services on a site at the Mental Health Centre in Markievicz House, Sligo.

The admission rate per 100,000 of population had reduced from 7.5 in 1991 to 6.2 in 2000. The Inspectorate was pleased to note that service providers were to focus on performance management this year in the context of a comparative assessment with other Boards through the measurement of readmission rates to in-patient care units by diagnostic category, length of in-patient stay by diagnostic category, suicide rate per thousand of the population, in-patient and community residential places per thousand of the population. A process to assess patients' satisfaction and experience with service provision was to be initiated and the Inspectorate looked forward to reviewing the report on the next inspection.

There were 591 spans of special one-to-one nursing supervision involving thirty-six patients in the Sligo Mental Health service in 2000 and three patients were prescribed ECT which was administered in Sligo General Hospital. Eight temporary patients had their temporary admission orders extended during 2000. An inspection of a number of case notes indicated a generally satisfactory level of clinical documentation. The final diagnosis was clearly recorded in notes examined and they were generally legible and easy to follow. Professional staff making inputs in the medical notes should write their name in capitals and then sign the entry and record their designation. This would ensure easy identification of the practitioner. The date records were entered was clearly recorded but the time was not. Recording the time would be useful in determining any delays in assessment or treatment. Patients' names were clearly recorded on each continuation page and this was satisfactory. Progress notes provided a chronological account of a patient's illness and subsequent notes explained clinical decisions. The admission notes were satisfactory. Pathways to admission, history of presenting complaint, past history, personal history, family history, current medication, mental state examination, physical examination and

immediate management plan were all documented. A discharge note was sent to the patient's GP on the day of discharge. A comprehensive discharge summary issued after discharge and contained information about medication on discharge and a summary of all relevant information with follow-up arrangements.

The standard of the nursing records inspected varied. A nurse care planning system was in use but ongoing staff training on the use of the nurse care plans was required. There were some difficulties in the admission unit implementing an ongoing nurse care planning system due to a lack of continuity of staff. Care plans seemed to be reviewed weekly but again standards varied. No primary nurse or team allocation system was in operation. An audit of the standard of nursing records was underway at the time of inspection with a view to identifying areas for improvement and staff development. The admitting nurse should sign the admission and assessment documentation. All entries in the records examined were dated but the time of entry should also be recorded. There was a need for greater correlation between the nursing goals and interventions. The daily report evaluations of nursing care plans should include patients' views on their progress, any negotiated changes in plans and results of changes.

The written drugs policy and procedure was last reviewed and updated in October, 2000. The standard of prescriptions varied. Some were in block letters which indicated a low risk of error, some were scripted and easy to read but a small number were difficult to read which indicated a moderate risk factor. All of the prescriptions were signed and dated individually and changes were written as new prescriptions. Drug allergies were recorded and information was rapidly available to staff. The number of discontinued prescriptions was greater than the number of current prescriptions in a number of cases and these cards should be rewritten. Information from pharmaceutical companies on prescribed medication was available in the nurses' office and this information was passed onto patients as appropriate.

A number of patients in the admission area were interviewed to ascertain their views on the care they received. All of the patients interviewed were satisfied with the courtesy and helpfulness of staff and with the admission procedures. They knew the names of their consultant psychiatrists and felt they had adequate access to them while hospitalised. One patient reported being informed of the nature of her medical condition ''to a certain extent'' and understood what was explained while another reported not being informed. Patients were generally satisfied with the quality and quantity of food provided. Those interviewed said they were not aware of their rights under the Mental Treatment Act, 1945 or on how to make a complaint if they felt aggrieved. One patient disliked sleeping in a six-bed unit and would prefer single room accommodation. Nevertheless, all of the patients reported that it was possible to get a good night's sleep. The cleanliness of the toilets and bathrooms was satisfactory when the domestic staff were on duty but not very satisfactory at night or if the domestic staff were off duty. One patient complained about other patients smoking in the toilet areas. While patients had adequate storage space for clothes and personal belongings, one patient would have liked a lock for the bedside locker. Facilities to wash personal clothing were available and all patients felt there was

adequate respect for privacy when they were given information or advice about their treatment.

Patients felt that the ward was reasonably well kept and safe and reassuring and they welcomed access to occupational area activities especially in the female ward. One patient indicated a need for additional space at this location. While patients reported that they had adequate contact with nursing staff, they did indicate a high turnover of nursing staff. Those in the female unit would have liked access to a card phone similar to that in the male admission unit. All reported easy access to hot and cold drinks and to fresh air, either accompanied or unaccompanied. Patients were actively involved in all decisions affecting their care and never felt obliged to repeat information about themselves to different professionals involved in their care. When asked what they thought should be done to improve their stay in hospital, one patient emphasised the need for patients and staff to abide by smoking rules and regulations and that these should be strictly enforced. Another requested access to a gymnasium for physical activity. One patient reported that the care at the Sligo Mental Health Unit was far superior to that provided in the general hospital. She particularly welcomed the care that was taken to ensure family members were involved in the care process and also that staff from the service were always available when required.

RECOMMENDATIONS

It is recommended that:—

1. Construction of the acute psychiatric unit at Sligo General Hospital proceed as quickly as possible.
2. More sector-based services be provided and a more sector-oriented philosophy and practice be put in place.
3. The day premises at Carrick-on-Shannon be refurbished or replaced.
4. Smoking in the seclusion room of the intensive care unit be discouraged.
5. Patients in the intensive care unit from the Donegal service be repatriated back to their own catchment area on a phased basis.
6. A written policy and procedure relating to the panic alarm system at the acute unit and intensive care unit be put in place and adequate monitoring take place to ensure the policy and procedure is implemented in full.
7. The policy and procedure relating to accidents, incidents and assaults be extended to include a regular audit providing an analysis by time, geographical location, cause of accident and nature of injury.

CHAPTER SEVEN

South-Eastern Health Board

CARLOW/KILKENNY MENTAL HEALTH SERVICE — 2001 INSPECTION

INSPECTED ON 20 AUGUST AND 16 OCTOBER, 2001

GENERAL DESCRIPTION OF THE CARLOW SERVICE

The catchment area population of 41,597 was divided into two sectors as follows:—

Sector	Population
Carlow North	20,597
Carlow South	21,000

IN-PATIENT CARE

In-patient care was provided at St Dympna's Hospital where 115 beds were provided in two male, one female and two integrated wards.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	12	5	2	—	19	20
3-12 Months	—	—	4	2	1	1	8	8.42
1-5 Years	—	—	4	5	5	2	16	16.84
> 5 Years	—	—	7	18	16	11	52	54.74
All Lengths of Stay	—	—	27	30	24	14	95	100
% of Total	—	—	28.42	31.58	25.26	14.74	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
1	18	1	7	4	1
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
4	10	2	29	18	95

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	54	36	90
Temporary	2	2	4
P.U.M.	1	—	1
Ward of Court	(8)*	(5)*	(13)*
Total	57	38	95

*Included in overall totals

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 315
Number of first admissions in 2000 74
Number of discharges in 2000 313
Number of deaths in 2000 13

Legal status of admissions
Voluntary 95.9%
Non-voluntary 4.1%

The number of admissions represented an admission rate of 7.6 per 1,000 of the catchment population. First admissions accounted for 23.5 per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	2	40	298
Day Centres	4	88	61
Out-patient clinics	5	211*	1,374

*No. of out-patient clinics held in 2000

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
4	23	4	41	—	—

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
6	15.5	120	35	11.5

COST

The cost of the Carlow Mental Health Service was £7.1 (€9) million in 2000.

GENERAL DESCRIPTION OF THE KILKENNY SERVICE

The catchment area population of 60,300 was divided into three sectors as follows:—

Sector	Population
Kilkenny North	20,100
Kilkenny East	20,100
Kilkenny West	20,100

IN-PATIENT CARE

In-patient care was provided at St Canice's Hospital, Kilkenny where ninety-two beds were provided in four integrated units.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	16	10	5	1	32	29.91
3-12 Months	—	—	6	2	4	2	14	13.08
1-5 Years	—	—	2	6	6	7	21	19.63
> 5 Years	—	—	2	17	8	13	40	37.38
All Lengths of Stay	—	—	26	35	23	23	107	100
% of Total	—	—	24.30	32.70	21.50	21.50	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
11	34	1	22	4	6
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
2	5	—	21	1	107

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	51	39	90
Temporary	7	1	8
P.U.M.	4	1	5
Ward of Court	3	1	4
Total	65	42	107

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 493
Number of first admissions in 2000 108
Number of discharges in 2000 473
Number of deaths in 2000 10

Legal status of admissions
Voluntary 90.3%
Non-voluntary 9.7%

The number of admissions represented an admission rate of 8.2 per 1,000 of the catchment population. First admissions accounted for twenty-two per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	10	80
Day Centres	6	104	110
Out-patient clinics	7	212*	1,905

*No. of out-patient clinics held in 2000

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
7	31	—	—	5	62

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
7	10.5	144.1	60.85	4.6

COST

The cost of the Kilkenny Mental Health Service was £6.5 (€8.3) million in 2000.

GENERAL COMMENTS

The regional management of the SEHB had recommended that the new psychiatric unit at St Luke‘s Hospital, which was ready for occupation, be made available to the medical service while alterations and restructuring took place at the hospital. This would provide additional accommodation for the medical, surgical, obstetric and neo-natal departments. It was proposed that, when the psychiatric unit opened, it should be given to the medical department for the winter period when the restructuring would take place. As soon as the work was completed, the medical department would vacate the unit and move back to enhanced accommodation in St Luke’s. The psychiatric unit would then be available as an acute admission unit for the joint Carlow/Kilkenny Mental Health Service. Psychiatric personnel had resisted this proposal. The unit was specifically funded for psychiatric purposes and should not be made available for any other purpose. Additionally, the mental health service was apprehensive that, if given over for medical use, it would never be returned to psychiatric use. The proposal was first initiated by the SEHB at a meeting in the Department of Health & Children at which representatives of the Board defended the

proposal; the meeting ended with a suggestion on the part of the Department that the Board might explore other alternatives and report back to the Department. This had not occurred at the time of the inspection.

It was still uncertain at the time of the inspection whether or not the Carlow/Kilkenny Mental Health service was going to move to the unit which had been planned, designed and funded specifically for that purpose. It would be a tragedy if this did not happen as the task of bringing the Carlow and Kilkenny services together, with the subsequent closure of admission facilities in St Dympna's Hospital, Carlow and St Canice's Hospital, Kilkenny, would not occur and the availability of St Canice's for other uses would be compromised. Additionally, a great deal of work had been undertaken by mental health personnel to deal with all the industrial relations issues arising from the closure of the afore-mentioned admission units and the transfer of staff to the new psychiatric unit. These negotiations had proceeded smoothly and were almost complete. It was the view of the mental health service locally, and one shared by the Inspectorate, that, were psychiatry not to move to the new unit, a crisis of credibility and good faith would inevitably ensue and greatly hinder further progress in the Carlow/Kilkenny mental health service.

General Comments specific to the Carlow Service

The task facing the Carlow service involved the amalgamation and rationalisation of community and in-patient services. A key element of this was the opening of the forty-five bed acute psychiatric unit at St Luke's Hospital, Kilkenny. Once this happened, the admission units in St Dympna's Hospital would close. Plans facilitating the integration of the two services were well advanced in Carlow. They showed considerable vision and an awareness of what the service should be striving towards. The future of St Dympna's centred on setting up an adequate rehabilitation service. The basic structure was already in place and all that was needed was co-ordination by a committed and dedicated multidisciplinary team to provide a specialised service for the combined Carlow/Kilkenny catchment area. The provision of a new fourteen-bed acute rehabilitation residence — Green Banks — would help considerably in this endeavour. It was likely that Green Banks would take patients from the existing rehabilitation residence — Clann Nua — and medium-stay patients from the new admission unit at St Luke's Hospital, Kilkenny. In addition, Green Banks would provide two crisis/respite places. Clann Nua would then be in a position to take further patients for rehabilitation from St Patrick's Ward in St Dympna's and form an extended rehabilitation residential unit.

Intellectual disability patients in Kelvin Grove were to transfer to a new purpose-built three-bungalow complex on the grounds of St Dympna's. Elm Court residents would be relocated when a house, which had been purchased, was renovated. Kelvin Grove would then be sold and Elm Court, a rented premises, would be relinquished. It was hoped that this new bungalow complex, as well as the transfer of patients with intellectual disabilities from St Canice's Hospital to Kilcreene (the former orthopaedic hospital in Kilkenny), would form the basis of a specialised learning disability service separate from psychiatry and staffed by specialist medical and nursing staff.

The existing admission unit in St Dympna's was to be converted into a comprehensive multidisciplinary day hospital. This was a badly-needed facility as the existing premises did not really function as a day hospital. Additional day centre accommodation separate from the new day hospital should be acquired, ideally in Carlow town, and out-patient clinics should be discontinued at St Dympna's. St Anne's and St Mary's Wards, which provided care for older patients, should be de-designated and form part of the service for older persons, either in association with the new psychiatry of later life service which was to commence in 2001 and/or with services for older persons at the Sacred Heart Hospital. The service had also purchased a new residence — Beechwood Drive — which was to be commissioned shortly.

The two Carlow sectors were well staffed and had a multidisciplinary team orientation with social workers, psychologists and the prospect of an occupational therapist. These sector services had family therapists and mobile outreach nurses in addition to community nurses who, with the existing sector staff, provided domiciliary and emergency services. It was anticipated that the day hospital would provide a seven-day emergency service so that all referrals not coming directly to the sectors would be routed through this service by a triage nurse and assessed by the SHO/registrar/consultant. The SHO/registrar would be rostered over the seven days. In this way, it was hoped to reduce in-patient admissions and refer patients to more appropriate services. It was hoped to refine the alcohol service which the Inspectorate felt should be decentralised and located away from St Dympna's with wider access to a range of referral agents.

Seclusion was used in St Dympna's on more occasions than the Inspectorate would wish. A particular problem related to one patient in Kelvin Grove who accounted for most of the seclusion episodes. However, new accommodation arrangements were being made for this patient which should obviate the necessity of using seclusion and allow for new approaches to the problems posed. Seclusion orders were usually signed by junior doctors and, in many cases, were illegible. ECT treatment was not provided at St Dympna's and, when it was required, patients and staff went to St Canice's in Kilkenny. This was unsatisfactory but would not be a problem when the new acute unit opened. Case notes were reasonably well organised, but the top sheet, admission entries and history-taking were unsatisfactory. Generally speaking, medical consultant entries for patients in the admission unit were frequent and up-to-date. However, this was not always the case for longer-stay patients. ICD diagnoses were not entered on the case notes and many entries were not signed legibly. A similar criticism applied to some prescription entries.

Management team meetings were held each month and minutes of the meetings were kept. Multidisciplinary team meetings took place every week. Fire precautions were adequate; there were written fire orders and equipment was checked regularly. There was a system of reporting and documenting accidents and injuries and health and safety statements were available. A complaints procedure was in place and there was a safety officer. An information and advice booklet was available to patients on admission. There was an induction process for all new staff and records were kept. All staff had FBAO and CPR training. However, the only ward identified as having an emergency tray was the

admission ward; it was necessary to highlight this because of the distances involved, particularly from St Anne's and St Patrick's Wards, to the admission unit. These wards should have their own emergency trays.

The patients interviewed were generally happy with their admission to and treatment in hospital. They knew their consultant psychiatrist, the medication they were taking and the reason why they had to take their treatments. They were satisfied with the quality and quantity of food provided and with privacy in the sleeping and toilet areas and felt they had time to discuss their problems with their assigned nurse. One patient, however, complained of 'roughness' on the part of some nursing staff. Apart from that, he was happy with the way he had been treated and did say that he had been somewhat un-cooperative.

General Comments specific to the Kilkenny Service

On the day before the inspection, twenty-one intellectually disabled patients from St Gabriel's Ward at St Canice's Hospital were moved to new accommodation in Kilcreene Hospital and St Gabriel's Ward had closed. Three tenders had been received to restructure and redevelop the ward to serve as a centre for older persons in association with the adjoining St Luke's Ward which currently served that purpose. Once this work was complete, the older patients in St Joseph's Ward in the original St Canice's Hospital building would transfer to the joint St Luke's/St Gabriel's Unit for older persons. It should be noted that the St Luke's/St Gabriel's complex was in the newer buildings to the rear of the original hospital. Once this occurred (and the admission units moved to the new unit at St Luke's Hospital), the entire original hospital building would be available for whatever purpose the Board decided. As things stood, much of the vacant space in St Canice's had already been converted and occupied by the SEHB as a complement to their adjoining headquarters.

The complete vacation of St Canice's Hospital by the psychiatric services also depended on alternative accommodation being found for the existing day hospital/day centre facility. Up to thirty patients came to the centre every day from community residences or their own homes before being dispersed to their various work locations such as the industrial therapy unit. This was an entirely unsatisfactory arrangement and occurred because there was no mental health headquarters/day hospital/community mental health centre in Kilkenny City. Unfortunately, no alternatives were in the pipeline and, although the mental health service had been actively seeking appropriate accommodation, nothing had transpired to date. Movement on this issue was essential, not only to improve day hospital facilities in Kilkenny but also to ensure that St Canice's was completely vacated by the mental health service. Meanwhile, the auxiliary hospital continued to function as a day centre, thus providing the only full-time community-based day programme in Kilkenny outside St Canice's.

Day centre facilities were available at five locations in the county, one day a week at Callan, Johnstown, Graiguenamanagh and Castlecomer. It was intended to extend the availability of day services in these locations, although many of the premises in which they were provided were rented and had limited availability. No new community residential accommodation had become available during the past year, but the Kincora and Maylock

residences had been upgraded. The process was continuing at Kincora. The Inspectorate had some apprehension about the job-sharing arrangement of the clinical directorship. This post should be a full-time position to ensure continuity, particularly given the impending closer amalgamation of the two services. Two of the other consultant posts were temporary and there was a shortage of psychologists and social workers. These issues needed to be addressed.

Special nursing was used infrequently in the Kilkenny Mental Health Service and seclusion was not used at all. Six patients were placed on special one-to-one nursing supervision in St Canice's Hospital during 2000. Seven patients had their temporary admission orders extended during the year. An examination of a file relating to the extension of a temporary patient reception order showed that an input was recorded in the file the day after the order was signed. Ideally, inputs relating to the assessment of a patient prior to the extension of the order and the reasons for the extension should be clearly recorded at the time of the extension. Forty-six accidents to patients and nineteen accidents to staff were recorded at St Canice's Hospital during 2000. Three assaults on patients by other patients and six assaults on staff were recorded in the same year. None of the accidents or assaults were deemed serious. Seven patients were prescribed ECT during the year and documentary procedures relating to ECT were satisfactory. Three complaints/appeals to the local complaints/appeals manager were recorded during 2000.

A number of prescription cards at a number of locations were inspected. The legibility of individual prescriptions was satisfactory; most were signed and dated individually and discontinued drugs were signed off using the discontinuation column. At one location, medicines were administered to patients, although some prescriptions were unsigned. The discontinuation column was also unsigned, although the drugs had been discontinued. Provision for recording the nurses' full signature on the drug administration card should be made. There was an increased risk of error if the number of discontinued prescriptions exceeded current prescriptions. This was noted on a number of cards examined in Admission Unit B and they needed to be rewritten.

An updated nurse care planning system using the 'Orem/Peplau nursing model' had been introduced in St Canine's Hospital and appropriate training was provided for staff. Care plans themselves were reviewed each week and more often if necessary. Overall standards were satisfactory. The nursing records identified problems that had arisen and action taken to rectify them. They were written clearly, dated accurately and usually signed in full with the patient's name recorded on each continuation page. The service should consider introducing a primary nurse care system in Admission Units A & B prior to relocating to the new acute unit at St Luke's Hospital. Whilst the standard of nurse record-keeping had improved considerably since the previous inspection and quite genuine efforts were made to adhere to the nursing model, it was suggested the records should reflect the involvement of patients in planning and making decisions about their own treatment. Entries about patients' wishes, preferences and suggestions about treatment approaches should be made and the evaluations of nursing care plans should include patients' views about their progress.

A number of medical records were examined. Admission pathways, clinical progress notes, discharge notes and discharge letters were satisfactory. Inputs from professional staff allied to medicine were appropriately recorded and formed an integral part of the file. While the notes were easy to follow, some signatures of the professionals making entries were illegible. It was suggested that entries should contain the full signature of the person making the entry with the name and designation of the person printed beside the signature. The time of entry should also be recorded. Provision for recording a patient's name on each continuation page within the medical notes was provided but it was not recorded in the notes examined.

The case notes inspected were of a poor standard; their construction, sequencing and layout was poor and badly required attention. Clinical admission notes were moderate and consultant entries were infrequent. In one case, the first consultant entry was a fortnight after the patient had been admitted. It appeared that admission decisions were often taken by junior doctors without conferring with the consultant and this may help account for the relatively high admission rate in this service.

The emergency medical procedures at the hospital were examined. The emergency boxes were checked regularly and appropriate records of all checks were kept. The clinical and administrative operational policies and procedures should be reviewed and updated. Additional policies, procedures and guidelines relating to patients voting, patients making a will whilst in hospital and locking external ward doors should be included in the revised policy and procedure manual.

A number of patients were interviewed to ascertain their views on the level of care provided. One patient was involuntary and the remainder were voluntary. They were generally satisfied with the courtesy and helpfulness of staff, knew the name of their consultant psychiatrist and had adequate access to them whilst hospitalised. Patients were not aware of their rights under the Mental Treatment Act, 1945 or on how to make a complaint if they felt aggrieved. It should be noted that this information was prominently displayed in the admission unit. These notices had obviously not been read by the patients. The patients interviewed felt they had satisfactory contact with the nursing staff. One patient said that, in order to improve a patient's stay in hospital, medical staff should spend more time with patients and give an indication of a possible discharge date. Another suggested more respite care and better follow-up of patients after discharge. The involuntary patient indicated a willingness to stay in hospital on a voluntary form having thought that she had been admitted to hospital voluntarily. Patients were not aware if a nurse was responsible for their individual care. This highlighted the need to introduce a primary nurse care system. When asked if they had been told anything about their prescribed medication and its long and short term effects, the patients interviewed reported being given no information.

Patients were satisfied with the cleanliness of toilets and bathrooms and reported that they could have a bath or shower when they requested it. Female patients, in particular, were not satisfied with the sleeping arrangements and requested more privacy. The female dormitory was used as a corridor with doctors, nurses and visitors passing through the bed

area to access the rest of the unit. The patients interviewed felt they had adequate storage space for clothing and personal belongings and easy access to washing facilities. One patient found the activities in the Occupational Therapy department beneficial, another patient attended once a week and other patients attended relaxation classes on a sessional basis only. All patients reported that the days on the ward were long and boring and requested easier and more continuous access to occupational, recreational or diversional therapies. The patients interviewed looked forward to relocating to the new acute unit at St Luke's General Hospital. One patient said it was a more modern building, safer with better lighting but would miss the freedom of the large grounds attached to St Canice's Hospital. One patient commented that he was looking forward to the relocation as he was always embarrassed telling his neighbours and friends of his admissions to St Canice's because of the perceived stigma associated with it. Another patient interviewed had no complaints about St Canice's and didn't mind where the admission unit was located as long as there was one available when required.

RECOMMENDATIONS

It is recommended that:—

1. The psychiatric unit be made available to the mental health service immediately.
2. Intensified efforts be made to secure a day hospital, community mental health centre and service headquarters in Kilkenny City to end the present unsatisfactory arrangement whereby patients attend St Canice's Hospital each day.
3. When the admission unit in St Dympna's Hospital closes, it be adapted to provide a comprehensive day hospital service. Day centre accommodation should be provided elsewhere and out-patient clinics on the campus should be discontinued.
4. A sector headquarters, as far as possible, be put in place in Tullow, where increased accommodation and availability is already about to occur, and in Leighlinbridge.
5. The proposed bungalows for improved accommodation for intellectual disability patients in Kelvin Grove be put in place as soon as possible and Kelvin Grove be closed and sold.
6. A specialised service be put in place for intellectual disability patients in Carlow and Kilkenny headed by a specialist intellectual disability psychiatrist.
7. St Mary's and St Anne's Wards be de-designated and form part of a specialised service for older persons, with links to both the later life psychiatry service and the service for older persons operating from the Sacred Heart Hospital.

TIPPERARY MENTAL HEALTH SERVICE — 2001 INSPECTION

INSPECTED ON 10 MAY, 2001

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 135,620 was divided into five sectors as follows:—

Sector	Population
Tipperary	25,774
Clonmel West	25,637
Clonmel East	26,380
Nenagh	27,535
Thurles	30,294

IN-PATIENT CARE

Acute in-patient care was provided at the fifty-bed St Michael's Unit, St Joseph's Hospital, Clonmel and long-stay in-patient care was provided at St Luke's Hospital, Clonmel where 174 beds were provided in three male, two female and two integrated wards.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	2	27	15	6	2	52	23.64
3-12 Months	—	—	7	7	1	3	18	8.18
1-5 Years	—	—	7	11	9	3	30	13.64
> 5 Years	—	—	15	61	14	30	120	54.54
All Lengths of Stay	—	2	56	94	30	38	220	100
% of Total	—	.91	25.45	42.73	13.64	17.27	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
1	89	7	37	4	4
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
5	11	—	46	16	220

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	110	85	195
Temporary	10	11	21
P.U.M.	3	1	4
Ward of Court	(4)*	(2)*	(6)*
Total	123	97	220

*Included in overall totals.

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 1,253
Number of first admissions in 2000 270
Number of discharges in 2000 1,247
Number of deaths in 2000 15

Legal status of admissions
Voluntary 86.9%
Non-voluntary 13.1%

The number of admissions represented an admission rate of 9.2 per 1,000 of the catchment population. First admissions accounted for 21.5 per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	3	Not available	452
Day Centres	—	—	—
Out-patient clinics	13	574*	2,776

*No. of out-patient clinics held in 2000

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
11	40	3	22	1	20

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
11	17	188	63	8

COST

The cost of the Tipperary Mental Health Service was £9.6 (€12.2) million in 2000.

GENERAL COMMENTS

Two major concerns relating to the Tipperary Mental Health Service remained. First, there was the slow pace of progress towards the provision of community-based facilities, including sector headquarters, community mental health centres, day hospitals and high-support residences for persons with intellectual disabilities in Cashel. The Inspectorate was informed that an opening date for this range of facilities had been set for 2003. This was disappointing as it had been hoped that these facilities would be in place much earlier. Second were the serious concerns with the unsatisfactory accommodation in St Michael's Admission Unit which was unsuited for its designated purpose in its present state. The Inspectorate noted that improvements had been made in the provision of additional offices in a new add-on building behind the unit and in the provision of new furnishings. However,

this was just a postponement of the real solution to the problem which was the replacement of St Michael's Unit with a modern substitute adapted to the provision of acute psychiatric care.

The admission of patients directly to wards with patients with intellectual disabilities and long-stay functionally-psychotic patients when St Michael's was full seemed to occur frequently at St Luke's Hospital. This admission practice must be condemned. It was inappropriate for patients to be admitted directly to such accommodation. The admission policies and decisions in St Michael's Unit seemed to be haphazard and uncontrolled. Fifty beds were provided in St Michael's Unit which, if properly used, should be quite sufficient to deal with the acute admission requirements of the catchment area. No bed management system appeared to be in place and patients arrived at the unit of their own volition or were referred by their GP without any community-based assessment and could be admitted on the decision of junior doctors. This situation was compounded by the lack of sector-based community mental health centres to which patients could be referred for assessment rather than directly to St Michael's. There was an urgent need for a bed manager in the unit. This person should be a consultant and should have the authority to manage beds in relation to admission decisions and to coordinate team meetings for the purpose of arranging discharges or transfers to more appropriate accommodation when this need became apparent. The mixture of patients with intellectual disabilities and functionally-ill psychotic patients in wards in St Luke's Hospital was also unacceptable.

There was concern at the lack of appropriate programmes for patients with intellectual disabilities. The Inspectorate would like to see a dedicated intellectual disability team defining a policy programme and objectives for this group of individuals who, for the most part, were only receiving custodial care. The lack of active rehabilitation programmes for the long-stay younger patients, notably in St John's Ward, was also disquieting. A designated multidisciplinary rehabilitation team was essential for these patients. A number of wards in St Luke's Hospital did not provide any separate accommodation for non-smokers who had to share day areas with smokers, thereby being exposed to passive smoking. This was unacceptable and breached health and safety regulations. Concerns about the diet of patients was also raised. On the day of inspection, the evening meal comprised chipped potatoes, minced sausage and bread and butter. This menu was apparently quite frequent and healthier meals were uncommon.

There were plans to provide a separate service for Tipperary North Riding based on an in-patient unit in Nenagh General Hospital but these plans had not developed to any degree. There was no mental health infrastructure in the Nenagh area i.e. no high-support residences, no day hospital etc. There were serious doubts about the feasibility of developing an individual mental health service for Tipperary North Riding based on an in-patient unit at Nenagh General Hospital because the catchment population was not large enough to justify and support a comprehensive catchment area service. The resources required for such a unit should instead be used to provide a comprehensive community-based service for the sector so that acute bed needs would be minimised and provided by the existing acute unit at Limerick Regional Hospital. The Morton Street premises in Clonmel had finally been sold to the Sisters of Charity and there were plans to transfer

the proposed services for the site back to the St Luke's Hospital campus. This tendency to centralise services on the St Luke's Hospital campus rather than trying to integrate services into the community was a cause for concern.

The appointment of a consultant for later life psychiatry and the commitment to provide the human resources and multidisciplinary team necessary to underpin this service was welcomed. However, the lack of a designated sub-unit in St Michael's Unit for psychiatric assessment purposes (which would be consistent with national policy) was a serious drawback and one that may not be resolved, given the difficulties already outlined in relation to St Michael's. In the meantime, the later life service was using beds in St Mary's Ward for assessment purposes and for continuing care. There was a plan to provide a day hospital for the later life service in Rose Hill, a two-storey detached house on the grounds of St Luke's.

The redecoration and refurbishing of St Paul's and St Mary's Wards in St Luke's Hospital was welcomed. The plan to integrate St Catherine's Ward and move it to the refurbished St Teresa's Ward would also improve the physical conditions in St Luke's.

The high rate of seclusion in the Tipperary Mental Health service was a cause for concern and raised the question as to whether this reflected an absence of other skilled ways of dealing with disturbed behaviour, particularly in the longer-stay wards. It was also disquieting that seclusion often appeared to be ordered by junior doctors. There were 165 episodes of seclusion involving sixty-one patients in 2000. A seclusion register was maintained and fifteen-minute nursing observations of patients in seclusion were recorded. The written seclusion policy and procedure should be reviewed and updated as seclusion was often confused with time-out and with both being used synonymously. The policy and procedure should contain information on time-out which was an entirely different approach to care. The system of pre-signing seclusion orders in St Brigid's Ward should be discontinued. A separate nursing seclusion care plan should be introduced for patients once a patient has been placed in seclusion. The care plan should include information on events prior to the seclusion episode, such as the actual behaviour of the patient and the consequences of the exhibited behaviour, interventions used prior to seclusion and the patient's response, and the actual reason for seclusion. The nursing observations of patients in seclusion should be incorporated into the care plan and the effects of seclusion should be evaluated on the termination of each episode.

There were 261 episodes of special one-to-one nursing supervision involving forty-one patients in 2000. The policy and procedure relating to observing and supervising patients should be reviewed and updated and it should be available in all clinical areas for staff information and reference. Observation status should be reviewed by the consultant psychiatrist and ward manager each day. Special nursing supervision should be audited and a minimum data set should include reasons for observation, specific levels of observation, length of time observed and any untoward incidents. Data such as the patient's age, sex, principle diagnosis and status under the Mental Treatment Act, 1945 should be included. Records of the patients' views on the process should also be kept and nurses' views of the

process should be collected regularly and used to improve the implementation of nursing supervision and observation.

Forty-nine patients were prescribed ECT during 2000. The treatment facilities at the St Michael's Unit were satisfactory. There was a specific ECT treatment record form which facilitated every day practice and audit. The consent form for ECT was satisfactory and the service had a comprehensive pre-ECT medical checklist and a pre- and post-ECT nursing checklist. All of this reduced risks of error and was satisfactory. Written information on ECT was available to patients and their relatives. There were 162 admissions on temporary orders and one admission on a PUM during 2000 and three patients had their temporary admission orders extended. All current involuntary admission orders were examined on the inspection and all had been completed satisfactorily. Forty-six accidents to patients and thirty-six accidents to staff were recorded in 2000 and two accidents required further medical intervention. There were three recorded assaults on patients by other patients and twenty recorded assaults on staff and three of the staff assaults required further medical intervention. The system of reporting and documenting accidents and incidents appeared to be satisfactory. Adequate training in CPR and FBAO was available to all staff and there was ongoing training on the management of violence and aggression. Health and safety statements were available in each local area and were up to date. The service management team met each month and minutes of the meetings were kept. Fire precautions within the service were satisfactory and records of all fire prevention training courses were kept.

A number of clinical files (medical, nursing and prescription cards) were examined. There was a need for written instructions on the filing of documentation within the medical records. The signature of the doctor making entries in the medical records was not always legible and their designation was not always recorded. The date of all entries within the records was recorded and it was suggested that the time of entry should also be noted. Recording the time was useful in determining any delays in assessment or treatment. The patient's name should be noted on each continuation page. The admission note on the medical file was comprehensive and set out pathways to admission, history of presenting complaint, past history, personal history, family history, mental state examination, physical examination, current medication and clear immediate management plan. All of this was satisfactory. Investigation reports were not correctly filed in a number of the medical files examined and there was a serious risk associated with a considerable number of loose pathological reports in each file. File covers were in good condition but storing loose clinical material in the back of files should be reviewed. A discharge note was sent to the patient's GP on the day of discharge and a typed letter was issued within a week of discharge. Discharge letters were readily available within the files and contained diagnosis, medication on discharge, a summary of all relevant information, follow-up arrangements and other matters pertinent to a person's care and treatment. Copies of discharge letters were easily accessed in the front of each file which was satisfactory.

Nursing care plans had been introduced in the service prior to the inspection. They were based on an agreed model of nursing care with specific goals, target dates and review dates using the new 'Peplau model' of nursing. The care plans were very much in their

infancy and adequate staff training on the new system was provided. Care plans were reviewed each day. There was provision for the introduction of a primary nursing system within the new nurse care planning system and this would be introduced once the new system became familiar to staff. The nurse care planning system should reflect the involvement of patients in planning and making decisions about their own care and treatment. Nursing evaluations should include patients' views about their progress, any negotiated changes in the plans and the result of changes. Nursing records examined confirmed that the patients appeared to settle into the ward at the end of the first day and all entries were made as soon as possible after events to which they related. It was noted on some records examined that the patient was given the chance to talk about his or her fears on admission. The records identified problems that had arisen and actions taken to rectify them. All of the records were accurately dated. The time of entry and the full signature with block lettering alongside the original signature should be considered and records should be written clearly so that text cannot be erased. The standard of entries in the nursing notes varied. Entries were made on a monthly basis in some of the long-stay areas and were made daily or more frequently in St Michael's Unit.

The policy and procedure in relation to the administration of medicines should be reviewed and updated. The legibility of individual prescriptions examined varied. Some prescriptions were blocked and signed and dated individually, others were scripted but were not difficult to read and a small number of scripted prescriptions were difficult to read. There should be one date and one signature for each prescription. Discontinued drugs were not always signed off using the discontinuation column and there was an increased risk factor in a number of locations where discontinued prescriptions were greater in number than current prescriptions. Prescribed medication was also recorded in the case notes. Most prescriptions were up-to-date but a number of prescriptions in the long-stay areas needed to be rewritten.

Policies, procedures and guidelines in accordance with service needs and current good practice were available in each clinical area. A core policy review committee should be established and all policies and guidelines reviewed and updated. In particular, a written policy relating to keeping some newly-admitted patients in their night attire and depriving them of access to day-time clothing was required. A smoking policy should be introduced and designated smoking facilities provided in St John's Unit and a written local policy and procedure on the use of the panic alert system in St John's should be available for staff information and reference. A multi-sensory garden should be provided adjacent to St Mary's Care of Older Persons Unit to allow ambulant patients full access to fresh air in comfortable and safe surroundings.

A number of patients were interviewed to ascertain their views on the level of service provision. Patients were generally satisfied with the courtesy and helpfulness of staff and with the admission procedures. One patient reported being on a waiting list for two weeks prior to accessing a hospital bed while the other patients interviewed had access to the hospital services as required. All patients knew the name of their consultant psychiatrist and had either daily/weekly access to them. One patient was not informed about the nature of their medical condition, including medication, while all the others reported being

informed and understanding what was explained to them. All were aware of their admission status but reported not being informed about their rights under the Mental Treatment Act, 1945 or on how to make a complaint if they felt aggrieved. One patient complained about the quality and choice of food. There was a need to review the menu cycle with the involvement of patients, particularly those in the long-stay areas. All patients were satisfied with aspects of privacy and dignity relating to their care and were satisfied with the cleanliness of toilets and bathrooms and had adequate access to the baths and showers.

Patients felt the sleeping arrangements in St Michael's Unit were adequate and it was possible to get a restful night's sleep. One reported difficulty in sleeping but stated this was due to the illness and not the ward environment. Others requested additional shower facilities be provided in the admission unit. All reported that there was adequate respect for their privacy when being given advice on treatment options. While some felt the ward environment was safe and reassuring, they indicated a need for redecoration and refurbishment. All patients interviewed had access to occupational therapy groups but two male patients emphasised the lack of variety and missed the carpentry classes which had been discontinued since their previous admissions. Patients reported easy access to a public telephone but some commented on the high cost associated with the use of the public telephone as compared to public telephones generally. They had access to fresh air while hospitalised, easy access to hot and cold drinks as required. The patients interviewed stated that they had not been told anything about their prescribed medication or its long and short term effects. One indicated that he had been given written information on his prescribed medication but had not read it as he fully trusted his doctor. All were satisfied with their involvement in decisions affecting their care.

RECOMMENDATIONS

It is recommended that:—

1. The provision of mental health facilities in Cashel be expedited.
2. St Michael's Unit be replaced by an up-to-date modern unit suitable for acute admission purposes.
3. A bed manager be appointed to St Michael's Unit to put in place a rational admission policy to eliminate the unacceptable practice of admitting patients directly to other wards.
4. A specialised multidisciplinary rehabilitation team be set up to put in place rehabilitation programmes for the long-stay functionally-psychotic ill patients in the Tipperary service.
5. A specialised team be put in place to plan an approach for the resettlement of all patients with intellectual disabilities in a specialised community setting.
6. Non-smoking areas be established in every ward in St Luke's Hospital and in St Michael's Unit.
7. A varied and healthy diet be provided for patients in St Luke's.
8. A formal decision be made on who provides services for the Nenagh sector. The Inspectorate would make a firm recommendation that responsibility for the services should pass to the Mid-Western Health Board incorporating the establishment of sector headquarters, day hospitals and residential community facilities for that sector.

WATERFORD MENTAL HEALTH SERVICE — 2001 INSPECTION

INSPECTED ON 12 APRIL, 2001

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 106,529 was divided into four sectors as follows:—

Sector	Population
West Waterford	29,843
Mid Waterford	29,843
East Waterford	29,843
South Kilkenny	17,000

IN-PATIENT CARE

Acute in-patient care was provided at the forty-five bed Department of Psychiatry, Waterford Regional Hospital and 133 continuing care beds were provided at St Otteran's Hospital.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	19	11	5	6	41	26.80
3-12 Months	—	—	3	5	4	8	20	13.07
1-5 Years	—	—	3	4	7	20	34	22.22
> 5 Years	—	—	3	18	19	18	58	37.91
All Lengths of Stay	—	—	28	38	35	52	153	100
% of Total	—	—	18.30	24.84	22.88	333.98	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
24	34	1	22	11	3
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
5	3	2	9	39	153

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	71	67	138
Temporary	5	4	9
P.U.M.	—	—	—
Ward of Court	1	5	6
Total	77	76	153

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 804
Number of first admissions in 2000 290
Number of discharges in 2000 787
Number of deaths in 2000 16

Legal status of admissions
Voluntary 90%
Non-voluntary 10%

The number of admissions represented an admission rate of 7.5 per 1,000 of the catchment population. First admissions accounted for thirty-six per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	20	434
Day Centres	3	60	201
Out-patient clinics	7	453*	5,264

*No. of out-patient clinics held in 2000

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
12	57	2	11	3	37

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
10	13	149	48.6	7.6

COST

The cost of the Waterford Mental Health Service was £8 (€10.2) million in 2000.

GENERAL COMMENTS

There had been few major changes in the Waterford Mental Health Service in the past year. A new community residence in Waterford city had been rented from the local authority and a part-time occupational therapist had been recruited. The service for later-life psychiatry had been consolidated with the provision of two community-based nurses and an NCHD. The extension of community-based services was essential for the development of the Waterford service. There was no proper day hospital in the service and the Brook House day centre premises was inadequate to fulfil this role because of the numerous other functions it fulfilled at present. The premises itself was of good quality and size and would make an ideal premises for a comprehensive day hospital facility for one of the sector teams. In order for this to occur, all the other functions currently provided by it (day centre activity, addiction services etc.) would need to be relocated to appropriate

settings. Day hospitals for the remaining sectors also needed to be acquired. Such initiatives were imperative if community-based assessment of patients was to be undertaken. To a large degree, assessment of patients mostly took place at Waterford Regional Hospital (WRH) apart from some assessments at out-patient clinics.

Many patients in Waterford city and the adjoining sectors spent long periods of time being brought by minibus from their residences to Brook House for day centre services. They arrived late in the morning and departed early in the afternoon; more time seemed to be spent in the minibus than at Brook House. This was unsatisfactory. The situation in West Waterford appeared to function satisfactorily where, in Dungarvan, the combined day centre/day hospital initiative with adjoining residences was working well. Generally speaking, the thirteen community residences provided by the service functioned well and were well maintained. The multidisciplinary teams needed to be strengthened, with particular emphasis on the recruitment of psychologists, social workers and occupational therapists. It was acknowledged that the recruitment of such personnel had been difficult in the past.

There were 125 patients in St Otteran's on the day of inspection and seven were temporary. Half of the patients had been hospitalised for five years or more and a large proportion of patients were over sixty-five years of age. There was a dedicated assessment and early intervention service for older persons in St Aidan's Ward which was run by a specialist later-life psychiatry team and a rehabilitation unit with a mix of medium and longer-stay patients offered limited rehabilitation potential under the present arrangements. St Enda's male ward catered for longer-stay patients with a range of disabilities and for direct admissions or transfers of shorter-stay patients perceived as unsuitable for direct admission to or retention in the acute psychiatric unit at Waterford Regional Hospital.

The commitment to closing St Otteran's Hospital seemed to rely on the retention of part of the thirty-eight acre hospital site with the provision of upgraded accommodation for older persons in St Monica's and St Joseph's Wards and the provision of a unit for 'difficult to manage' patients and rehabilitation patients. There was a commitment to transfer older patients in St Aidan's continuing care/dementia/organic unit to St Patrick's Hospital which catered for older persons in the region. As a first step towards providing a comprehensive service for older persons in Waterford city and county, it was argued that St Monica's and St Joseph's Wards should be de-designated from the mental health service on the basis that the essence of care for these patients involved physical care rather than psychiatric care which, in most cases, was minimal. There was some reluctance on the part of clinical staff in St Otteran's to de-designate these units because control of the beds would be lost to the mental health service and difficulties would arise in finding suitable accommodation for patients who had grown old in residential accommodation. The Inspectorate felt this was not an adequate reason for resisting de-designation and the practice of placing patients from St Otteran's in community settings and then returning them to the hospital defeated its own purpose. Rather, it was felt that, when such people became older and were no longer able to physically manage in residential accommodation, nursing home places should be provided for their care. Alternatively, they should be catered for by a comprehensive service for physically impaired older persons.

The physical and therapeutic environment in St Enda's Ward was quite antiquated, of poor quality and manifestly unsuitable for the variety of functions it was supposed to provide. It was of particular concern that a patient suffering from Huntington's Clorea had been admitted to this locked ward. It had placed a strain on staff resources to provide the best possible care for the patient in what was a most unsuitable environment. The service acknowledged that St Enda's needed to be closed and that a replacement facility for more difficult to manage patients was necessary. Various locations had been discussed as suitable for this purpose.

The active rehabilitation of younger long-stay patients in St Otteran's, combined with additional community-based residential accommodation, was required. The local Mental Health Association had indicated a willingness to provide a premises with support from the Department of the Environment should a suitable site be located. There had been some talk of using part of the grounds of the Ard na nDeise residence for this purpose but there was some resistance to this idea because of the undesirability of having two residences so close together. The number of new long-stay patients in the service during the past year (nine) was rather high and reflected the need for more active rehabilitation with a dedicated team, either part-time or full-time, allocated to this function.

There were 755 admissions to in-patient care in 2000 which resulted in a high admission rate for the service. The high numbers reflected the lack of community-based assessment and the shortfall of community-based alternatives. The proportion of first admissions at thirty-seven per cent was much higher than the national average of twenty-six per cent and was further confirmation of the necessity for more rigid community-based assessment of patients presenting to the service.

The psychiatric unit at Waterford Regional Hospital was of good quality and quite spacious. However, its division into acute and sub-acute areas posed certain problems. The unsatisfactory physical nature of the acute area has been highlighted in previous reports; the claustrophobic atmosphere generated by its configuration and concerns from a health and safety point of view regarding the centrally-placed nurses' station which left staff vulnerable to assault from behind. There were no adequate interviewing facilities or appropriate smoking arrangements in the high observation area. In addition, the high observation area was always locked with consequent restrictions on freedom of movement, particularly for voluntary patients. Considering the high observation area was always locked and the high level of special one-to-one nursing supervision, it was surprising that some patients were transferred, following admission, to the unsatisfactory St Enda's Ward in St Otteran's. Some beds in the unit had been made available to the psychiatry of later life service but it was an unsatisfactory arrangement and some attempt should be made to structure a separate unit for older persons within the fabric of the unit. Only a few beds were necessary and there was separate space within the unit to make this possible given an imaginative approach to the problem.

Clothing throughout the service was personalised and privacy in bed areas was safeguarded through the provision of curtains and rails around the beds, except in part of St Joseph's Ward. Some of the wards in St Otteran's had been repainted, notably in St Aidan's, and painting was to commence in St Clare's Ward shortly after the inspection.

New duvets had been provided and new curtains were to follow in this ward. Patients' had adequate storage space; full-length lockers were generally available. The physical conditions in St Monica's Ward were poor. In particular, the roof area was problematic with draughts and minor rain leakage in two areas during bad weather. An ant infestation, which was a recurrent problem in St Monica's, was being dealt with at the time of inspection.

Seclusion was used in the Waterford service. The seclusion registers at both hospitals were up-to-date and well maintained, although in certain instances the seclusion order was signed by a junior doctor and on at least one occasion a patient had been secluded without any reference in the case notes to the event and the reasons for it. Documentation in the medical case notes on admission was adequate and consultant entries followed shortly after admission in most instances. However, the layout of the case notes was unsatisfactory; there was no top sheet where patient details should be clearly set out, although a short form was filled out in the general admission area and appended to the case notes on admission. ICD diagnoses were not evident in the case notes or at the beginning of the case record. Case note organisation was not entirely satisfactory in sequential terms and laboratory results etc. were filed randomly in an envelope on the back cover.

An improved nursing care plan system had been introduced just before the inspection. Consequently, it was too early to assess how this was working. Induction courses and training in aspects of aggression management, handling of loads, safe lifting techniques, CPR and FBAO were provided and records were kept. There was a shortage of nurses and it was proving difficult to staff additional community-based services. It was noticeable that administrative nurses were all based in St Otteran's and the Inspectorate repeated its view that Assistant Directors of Nursing should be appropriately allocated to the service sectors and to the acute psychiatric unit at Waterford Regional Hospital in a coherent and logical fashion. A new identification badge for nurses was being prepared at the time of inspection.

Patients were informed of their rights under the Mental Treatment Act, 1945 on admission to the service and a new patient booklet, which had the advantage of being explicit, concise and attractive, was distributed to all newly-admitted patients. A number of newly-admitted patients in the acute psychiatric unit were interviewed and most seemed to be satisfied with the care and attention they were receiving, although one patient complained that she felt the nursing input was not personalised or concentrated enough. Other patients, particularly in the acute area, complained of boredom during the day. It was true that, on the day of inspection, none of the patients in the acute area had attended the occupational therapy department. In fairness, however, some of these patients were not yet at a stage where they would have benefited from such attendance.

RECOMMENDATIONS

It is recommended that:

1. A definitive plan be put in place to deal with the future of St Otteran's Hospital and the various categories of patient within the hospital. It was obvious that staff had been thinking about the issue but not in a concentrated and definitive way. It was felt that, if the service was to move on, this issue needed to be addressed as a matter of urgency.

2. Day hospital and sector headquarters be provided in the service sectors with a start being made by devoting Brook Lodge exclusively to one of the Waterford sector services.
3. Dedicated accommodation be provided in the acute psychiatric unit at Waterford Regional Hospital for the later life psychiatry service.

WEXFORD MENTAL HEALTH SERVICE — 2001 INSPECTION

INSPECTED ON 3 MAY, 2001

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 103,989 was divided into three sectors as follows:—

Sector	Population
Wexford	38,980
Enniscorthy	30,379
Gorey/New Ross	34,680

IN-PATIENT CARE

In-patient care was provided at St Senan's Hospital, Enniscorthy where 185 beds were provided in four male, four female and three integrated units.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	31	12	4	6	53	27.18
3-12 Months	—	—	6	4	3	8	21	10.77
1-5 Years	—	—	10	13	10	12	45	23.08
> 5 Years	—	—	12	25	16	23	76	38.97
All Lengths of Stay	—	—	59	54	33	49	195	100
% of Total	—	—	30.26	27.69	16.92	25.13	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
9	72	3	34	7	2
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
6	9	3	45	5	195

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	83	68	151
Temporary	10	7	17
P.U.M.	12	11	23
Ward of Court	2	2	4
Total	107	88	195

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 546
Number of first admissions in 2000 143
Number of discharges in 2000 536
Number of deaths in 2000 10

Legal status of admissions
Voluntary 88.6%
Non-voluntary 11.4%

The number of admissions represented an admission rate of 5.25 per 1,000 of the catchment population. First admissions accounted for twenty-six per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	Variable	700
Day Centres	3	89	296
Out-patient clinics	4	301*	1,373

*No. of out-patient clinics held in 2000

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
10	31	7	37	2	23

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
10	10.5	160	44.5	6.1

COST

The budget for the Wexford Mental Health Service was £9 (€11.4) million in 2000.

GENERAL COMMENTS

There had been considerable improvement in the physical conditions in St Senan's Hospital in the past year. The most important improvements involved repositioning the admission/acute units. Male admissions only were now admitted to the former integrated

admission unit which had been upgraded to some degree. The reduction in numbers being admitted to the unit had improved the former congestion. However, the premises was far from ideal as an admission unit and highlighted the urgency required in providing an acute admission unit at Wexford General Hospital as soon as possible. The male admission unit was known as St Clare's Ward. The new female admission unit on the second floor of the hospital was known as St Brigid's Ward. While staff reported the new arrangement as a considerable improvement on former conditions, it was only a stopgap arrangement. Congestion, overcrowding and lack of privacy rendered it unsuitable as an admission unit on an ongoing basis.

Many of the long-stay wards in the hospital had new tables and chairs, new beds and new wardrobes. In addition, new curtains had been provided in many areas and a lot of repainting had been undertaken. A major (and costly) drainage and sewage system was being installed and this had caused considerable upheaval in the grounds of the hospital because of the plumbing and excavation being undertaken. To some extent, the upheaval to many patients was limited because many patients on the middle and upper floors of the hospital did not have any easy access to the open air or the gardens. Additional disruption had been caused by the installation of an automatic fire alarm system throughout the hospital.

A new consultant for the psychiatry of later life had been appointed to the service and had started work just prior to the inspection. It was hoped that the physical and human resources necessary to underpin the post would be appointed soon. With the arrival of the fifth consultant, the clinical director had relinquished responsibility for one sector of the service but had taken on responsibility for the rehabilitation of long-stay patients. He had also opted out of the on-call rota which was causing some discontent among some of his fellow consultants. Attempts to recruit a number of social workers was underway. The posts had been advertised; one for a team leader and one for a basic grade social worker.

It was felt that there had been considerable administrative and industrial difficulties in the service over the past few years, some of which were reported in the national press. The issues relating to these matters remained unresolved. There had been some improvement in establishing a management group for the service which met regularly, took minutes of meetings and planned policy and decisions regarding the future direction of the service. This was especially important as St Senan's was in a state of transition. It required movement in relation to its intellectually disabled patients, its older patients and its acute and long-stay functionally-ill patients. The presence of forty-five patients with an intellectual disability segregated mainly in two wards but with some still mixed with other patients with different needs in generic wards was unsatisfactory. There appeared to be a realisation that these patients were misplaced and management seemed resolved to finding suitable alternative community placements for them. There were plans to provide accommodation in Courtown and in Gorey where a day programme was to begin shortly after the inspection. There was an understanding that the sector headquarters, community mental health centre and day hospital in Wexford town needed to be replicated in the other sectors. In Enniscorthy, a convent was to become available in the town centre and it was hoped it would be used for this purpose. Similar initiatives were required in the New Ross/Gorey

sector. However, the Inspectorate felt that a clear vision for the future of St Senan's had not been addressed by the health board itself.

The Inspectorate were not convinced that admission decisions were being made by the most appropriate personnel i.e. the consultants. Reviewing a number of admission case notes, it appeared that this was not always the case. Note-taking, particularly in the long-stay wards, was unsatisfactory and the statutory obligation to provide six-monthly reviews was not adhered to in many instances. Consultant entries were often infrequent and, in some cases, had not been made for a number of years. Nursing staff did not wear name badges and nursing notes, rather than care planning records, seemed to be used in most wards. Formal case reviews in long-stay wards did not take place and, if a determined rehabilitation effort was to be made, then a much more intensive and professional approach needed to be taken by a committed multidisciplinary rehabilitation team.

There were 602 episodes of special one-to-one nursing supervision involving ten patients in St Senan's in 2000. Sixty-one patients were admitted on temporary certificates and one patient was admitted on a PUM certificate. There were eight temporary admission order extensions in 2000 and medical assessments prior to making a decision to extend the temporary orders were appropriately recorded in all cases. The temporary orders for all involuntary patients were in order. Thirty-eight patients were prescribed ECT in 2000. The ECT consent form was satisfactory and the ECT procedure and guidelines were available in the clinical areas. They should be reviewed and updated. The pre- and post-ECT nursing checklist system should also be reviewed and updated. Seclusion was used in the intellectual disabilities area on a small number of occasions during 2000 and the episodes were of short duration. The seclusion register was appropriately recorded. Twenty-one patients discharged themselves against medical advice during the year.

No information on a research project undertaken in the hospital and governed by the Clinical Trials Act 1987 to 1990 was available. Twenty-five accidents to patients and thirteen accidents to staff were recorded during the year and none were deemed serious. Nine assaults on patients and twenty-one assaults on staff were recorded. Two of the staff assaults required further medical intervention. The procedures for reporting accidents and assaults was satisfactory. Six complaints/appeals were made by patients or their relatives to the local complaints appeals manager and they appeared to have been dealt with satisfactorily.

Fire precautions at the hospital had improved since the previous inspection with the installation of a new automatic fire detection system. Records of fire drills and evacuation precautions were appropriately recorded. The health and safety statement for the hospital and local units was reviewed in 1999. The hospital had seconded two members of staff to train as CPR and FBAO trainers. Once trained, they would organise in-service training for all staff at St Senan's Hospital. Training courses on the management of aggression and violence were provided twice a year and records of the training courses and those attending were kept.

A number of clinical files were examined and overall standards varied, particularly between the acute units and the long-stay areas. In the acute unit, written instructions on filing documentation within the records were available. Pathways to admission were clearly documented, as was the history of presenting complaint, past history, personal history, family history, mental state examination and physical examination. The patient's current medication was clearly recorded in the notes and there was a clear summary and immediate management plan. Progress notes were relatively easy to follow. However, all entries should be signed in full with the date and time of entry clearly recorded. While space for the patient's name was provided on each continuation page, this was not always recorded. Investigation reports were filed correctly, correspondence was filed in chronological order and inputs from disciplines allied to medicine were appropriately recorded and formed an integral part of the clinical file. File covers were generally in good condition but storing loose clinical material in the front of the file should be reviewed. Discharge letters contained diagnosis, medication on discharge, a summary of all relevant information, follow-up arrangements and prognosis. Copies of discharge letters were easily accessible and discharge letters were issued to the GP within seven days. Patients on discharge were given a clinic card with an appointment for an out-patient clinic.

Medical files examined in the long-stay areas indicated a need for greater attention to medical note-taking. Section 5 of the Mental Treament Regulations 1961 (S.I. No. 261 of 1961) sets the minimum standards in relation to entries in medical case records. Section five(x) states an entry giving particulars of the condition of the patient each half year. These regulations were not being complied with. For example, one patient had a medical input in November 2000 and no entry since. On another note examined, the last entry dated from 1999. Another had seven inputs in the medical notes since 1997 and the last physical examination of the patient was dated June, 1999. One patient had a psychiatric review on 1 March, 2000 and there were no further entries in the notes until 9 April, 2001 when a doctor had been called to see the patient who was complaining of feeling unwell. All of this required attention.

The written drugs policy and procedure needed to be reviewed and updated. A number of prescription cards were checked and the legibility of individual prescriptions varied. Some prescriptions were in block capitals and not scripted, others were scripted but were easy to decipher, while some were quite difficult to read. All prescriptions should contain the full signature of the prescriber and should be dated individually. Information on drug allergies did not appear to be rapidly available to staff. While some discontinued drugs were signed off using the discontinuation column, this was not always the case. The system of drawing a line through a discontinued drug and not signing the discontinuation column required review. Some prescription cards were last reviewed in 1999, particularly in the long-stay areas, and these cards needed to be reviewed and rewritten.

All patients in the long-stay wards at St Senan's Hospital should be individually assessed for their future care and placement needs. The older patients in the elderly care wards would continue to be cared for in that setting. Consideration might be given for specialised care by the developing psychiatry of later life service for these patients. Case summaries

on all patients in the long-stay wards should be updated twice a year. There should be bi-monthly ward meetings where nursing staff, consultants and ward doctors could meet to discuss patient care and progress. The bi-annual patient review should record the patient's age, diagnosis, a brief summary of the patient's history and background, particular mental/behaviour problems in the past, particular physical problems in the past, a summary of physical and mental behavioural problems in the past six months, a note of current mental state and current medications. A note of the patient's response to current medications, any changes in medication and the reason for the changes should be recorded. Notes of investigations planned and reasons for investigations should also be recorded.

The nursing records were nursing progress reports rather than a nurse care planning system. Nursing records in the admission areas confirmed that patients appeared to settle well into the ward at the end of their first day. Entries were made as soon as possible after the event to which they related. Records were dated accurately and, for the most part, signed in full. Again, standards varied across different locations. The patient's name should be recorded on each continuation page of the nursing notes. The records should reflect the involvement of patients in planning and making choices and decisions about their care and treatment. The notes should be audited to assess standards of record-keeping and to identify areas for improvement and staff development. An appropriate nurse care planning system using an agreed model of nursing care should be introduced. In tandem with this, a primary nurse care system should be introduced in the admission units.

Training programmes should be put in place in all of the long-stay areas, the day centres and occupational therapy departments to prepare patients for the changeover from Irish Punts to the Euro. Information packs and a video were available from the Euro Conversion Board.

A number of patients were interviewed to ascertain their views on the level of service provision. The patients interviewed were satisfied with the admission process, access to the service and the courtesy and helpfulness of staff. They all knew the name of their consultant psychiatrist and saw them twice a week while hospitalised. Patients reported being informed about the nature of their medical condition, including medication, and all reported understanding what was explained to them. They were satisfied with the quality and quantity of food provided, were aware of their legal status while hospitalised and were informed of their rights under the Mental Treatment Act, 1945. One temporary patient had his rights fully explained but, due to his illness, had not comprehended fully the explanation given. However, he had accessed it later in the information booklet.

One female patient commented on the need to upgrade the shower units in St Brigid's Ward. The patients interviewed felt it was possible to get a good night's sleep and generally found the ward environments safe, reassuring and well-kept. One male patient commented on the improvements to St Clare's Ward since his previous admission. The additional space, lack of overcrowding, redecoration and access to a telephone were all welcomed. All patients interviewed commented on the inadequate smoking facilities. The rooms provided were too small and the ventilation was inadequate. One patient on St Brigid's Ward commented on the lack of privacy when being given information or advice

in the nurses' station as conversations from that location could be overheard in the general ward area. All patients reported adequate access to occupational and diversional therapies and found them helpful. Patients felt they had enough contact with the nursing staff but were not aware if there was an individual nurse primarily responsible for their care. All patients reported an active involvement in all decisions affecting their care.

RECOMMENDATIONS

It is recommended that:—

1. A clear phased plan for the future of St Senan's Hospital, in conjunction with that of the Wexford Mental Health Service, be outlined by the Board.
2. Sector headquarters and day facilities like those in the Wexford sector be provided as part of a Mental Health Centre in the remaining sectors.
3. Patients in St Senan's Hospital with an intellectual disability be placed in appropriate community-based settings.
4. The later life psychiatry service be given the necessary human and physical resources to allow it to function effectively and efficiently.
5. A multidisciplinary rehabilitation team be established in order to rehabilitate the younger long-stay patients in St Senan's to community settings.
6. More attention be paid to medical note-taking in order to fulfil statutory obligations.
7. The nursing staff wear identification badges.
8. In-patient admission facilities be transferred to Wexford General Hospital through the provision of an acute psychiatric unit in the hospital as soon as possible.
9. The re-settlement team focus attention on filling vacancies in community residences and review the potential for upgrading some of the low-support residences to medium and high-support residences in order to cater for older, more dependent patients in St Senan's Hospital who are suitable for community residential accommodation.

CHAPTER EIGHT

Southern Health Board

KERRY MENTAL HEALTH SERVICE — 2001 INSPECTION
INSPECTED ON 30 AND 31 JULY, 2001

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 126,130 was divided into four sectors as follows:—

Sector	Population
Listowel	21,195
Tralee East/Dingle	33,226
Killarney West/Tralee West	37,319
Killarney East/Kenmare/Cahirciveen	34,390

IN-PATIENT CARE

In-patient care was provided at St Finan's Hospital where 186 beds were provided in seven male and five female wards and at the forty-eight bed acute unit, Tralee General Hospital.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	1	17	22	4	6	50	22.03
3-12 Months	—	1	1	4	1	2	9	3.96
1-5 Years	—	—	6	6	4	2	18	7.93
> 5 Years	—	—	12	59	46	33	150	66.08
All Lengths of Stay	—	2	36	91	55	43	227	100
% of Total	—	0.88	15.86	40.09	24.23	18.94	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
11	107	—	32	8	6
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
6	10	1	46	—	227

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	105	73	178
Temporary	8	12	20
P.U.M.	9	10	19
Ward of Court	7	3	10
Total	129	98	227

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 881
Number of first admissions in 2000 282
Number of discharges in 2000 844
Number of deaths in 2000 22

Legal status of admissions
Voluntary 89.4%
Non-voluntary 10.6%

The number of admissions represented an admission rate of seven per 1,000 of the catchment population. First admissions accounted for thirty-two per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	3	59	224
Day Centres	5	95	146
Out-patient clinics	8	296*	1,279

*No. of out-patient clinics held in 2000

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
12	61	—	—	4	61

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
11.67	10.33	255.5	80.67	3.33

COST

The cost of the Kerry Mental Health Service was £11.4 (€14.5) million in 2000.

GENERAL COMMENTS

Considerable progress had been made in extending the community-based mental health services in Kerry during the past year. The Ballydibeen Centre for patients with a learning disability had opened and accommodated twenty-eight patients formerly in St Finan's and

also provided two respite beds. As a consequence, three wards in St Finan's had closed. Ballydribeen was not designated under the Mental Treatment Act, 1945 for the reception of patients with mental illness, but it was staffed by Kerry Mental Health Services staff. There was a dedicated consultant and an assistant director of nursing.

The community residence in Rathmore had been extended and catered for an additional four patients who had moved there from St Finan's. The new day hospital, Caherina House in Tralee, was expected to be commissioned within a matter of months, replacing the older, unsatisfactory building on the same site. A new fourteen-place high-support residence in Listowel was under construction and well advanced. It was hoped it would receive patients from St Finan's Hospital by February, 2002. A new day centre premises was acquired in Castleisland through both voluntary and health board effort. Staff were being assigned to this unit and it was to open shortly as a Monday to Friday operation, which would be a considerable help to community services in North Kerry. A replacement centre was planned for Caherciveen and two additional residences acquired nearby. Similar initiatives for the extension and replacement of existing services in Dingle were also under way. Finally, a premises was being sought in Kenmare to provide day services in this area of South Kerry. All of this represented a considerable degree of progress and initiative on the part of this service which was most refreshing and encouraging.

Additionally, the catchment area was to be augmented by the addition of a further sector and a fifth consultant in general adult psychiatry had been approved. Plans by the Kerry Mental Health Service to extend community residential accommodation and to provide an intensive care facility for the county had been at an advanced stage but, unfortunately, had been frustrated by a report of a survey group dealing with the needs of older persons in community care in Killarney. The training workshop, which was located in the ground floor of the Cherryfield building in Killarney (and which had a fine high-support residence in the upper storey), was to be transferred to new premises at the back of St Finan's Hospital. Additionally, this survey report recommended taking over the top floor in Cherryfield for community-care purposes and transferring the high-support residence to Park Lodge in Killarney, a former guesthouse providing accommodation for refugees. These proposals ran counter to plans by the Kerry service to provide an intensive care unit by amalgamating the Ross and Mangerton buildings close to St Finan's Hospital. Park Lodge was to accommodate the transfer of the residents from Cherryfield high-support residence. The proposals also negated the possibility of creating a modern up-to-date sector headquarters and day hospital for the Killarney sector, which the Inspectorate felt was badly needed.

Approximately sixty per cent of patients remaining in St Finan's were older persons. The Inspectorate suggested that the Board should concentrate on refurbishing the hospital and providing a service for the care of older persons on this site. It was recommended that a consultant post in later life psychiatry be created with an accompanying specialised multidisciplinary team to work in association with services for older persons as well as dealing with the psychiatry of later life. With the increasing vacant space in the hospital as more patients moved out to community residential care, it was also suggested that community care services could be located at the hospital instead of interfering with the

progress being made by the Kerry Mental Health Service through the requisitioning of the Cherryfield premises and the Ross and Mangerton site.

This initiative would allow the mental health service to close St Finan's, the only appropriate solution to the unsatisfactory conditions in the hospital. In particular, the male long-stay wards were most unsatisfactory, with patients spending most of their day in these surroundings, unoccupied and leading rather purposeless lives. Similarly, some of the wards for older people, both male and female, did not appear to serve any psychiatric purpose. Often, persons with physical illnesses were cared for in these wards and many never left the wards before they died.

The deficiencies of the wards in St Finan's were known and acknowledged and were being addressed through action by the service providers. However, many of the wards were institutional and the bleak and uninviting decor did nothing to facilitate a warm and supportive environment. There was an inadequate supply of lockers in St Joseph's Ward and new lockers and bed screens were needed in Our Lady's Ward which also required redecoration and refurbishment. A replacement emergency resuscitation trolley was needed in Our Lady's Ward. The importance of a formalised system of regular checks on this trolley was emphasised to ensure that drugs had not expired. Apparently, a formal system was in place where drugs were reviewed on a rotational basis every three months, with the date of expiry marked clearly on the cover of each tray.

There were two locked wards in St Finan's for 'disturbed' or 'difficult to manage' patients who badly needed active rehabilitation. One was male — St Denis's and one female — St Bernadette's. There was a proposal that these wards should be closed and the patients moved to St Peter's or St Martin's Wards which had closed with the transfer of patients to Ballydibeen. These wards should be refurbished and upgraded at a cost of almost £300,000 (€381,000). As the Gardaí refused to convey persons on PUM forms to the psychiatric unit in Tralee, they were brought to St Finan's and admitted to the locked wards. There were sixty-one such admissions during 2000. It was unsatisfactory that an individual's first experience of psychiatric in-patient care should be in such depressing wards. The Inspectorate had written to the Garda Commissioner at the behest of the clinical director requesting that PUM patients be brought to the Psychiatric Unit at Tralee General Hospital rather than to St Finan's.

The question of alternative accommodation for the patients in St Denis's and St Bernadette's Wards was linked to the perceived requirement for a high observation area in the psychiatric unit, Tralee General Hospital. Two rooms in the unit were used for seclusion, as well as for ordinary purposes, but they were neither safe nor satisfactory for dealing with very disturbed patients as they were never designed for that purpose. A proposal had been made to create a 'unit within a unit' by extending the existing unit outwards to provide four beds in a self-contained sub-unit. The Inspectorate acknowledged the need for improved accommodation for disturbed patients and recommended a high-observation area rather than a separate sub-unit which would entail a number of difficulties, including appropriate staffing. It was agreed that the issue would be investigated and the outcome reported to the Inspectorate.

The issue of whether a separate intensive care unit was required for the catchment area was also a matter for discussion. It was acknowledged that the intensive care unit in Cork was too far away to be an operational possibility. A high-support secure facility to cater for approximately twelve patients was probably required but it was felt this should be an appropriately staffed 'hostel ward' rather than an intensive care unit. The physical location of such a unit had been thought through by the Kerry team, with three possibilities emerging. The first was to place it in the grounds of Cherryfield; the second was to adapt the Ross and Mangerton residences for this purpose; and the third was to establish it on a green-field site on St Finan's campus. The first two alternatives appeared to have been overtaken by the recommendations of the review group already referred to and the matter remained under discussion.

The psychiatric unit at Tralee General Hospital was working satisfactorily but there did appear to be a problem with overcrowding when the fifty-bed complement was exceeded. The response to this had been to put up extra beds, a solution which was unsatisfactory. It was felt that triaging and assessment were not as rigorously carried out or as effective as might have been the case. It was reported, for example, that patients for assessment made their way to and were received in the unit directly without being filtered through the A & E department where the patient should first be assessed physically and then psychiatrically. Assessment should, as far as possible, be carried out in a community setting but the lack of appropriate physical resources for this purpose in the sectors was noted. It was hoped to provide such facilities before too long. Alcohol-dependent patients were still admitted to the unit for detoxification. This was not unique to the Kerry service and it was the view of the Inspectorate that detoxification should be a medical procedure, carried out by primary care providers or in acute cases in beds on medical wards. The physical conditions, the medical note-taking and the general documentation of the unit were satisfactory.

There were 138 episodes of seclusion involving twenty-six patients in the Kerry Mental Health Service during 2000. Documentary procedures relating to seclusion were examined and the need for standardised procedures was noted. Medical notes contained written information relating to a medical assessment of patients prior to each seclusion episode and fifteen-minute nursing observations were recorded which was satisfactory. It was suggested that the nursing observations should also record when seclusion commenced and terminated. Twelve patients discharged themselves from the service against medical advice and forty-one patients in Tralee General Hospital were prescribed ECT in 2000. Documentary procedures relating to the administration of this therapy were satisfactory. Records relating to the number of patients placed on one-to-one special nursing supervision and records relating to extensions of temporary admission orders should be kept at both in-patient locations.

There were thirty patients hospitalised in St Finan's on temporary certificates on the day of inspection and eleven had had their temporary admission orders extended during 2000. A further sixteen patients were hospitalised on PUM certificates and eight patients were Wards of Court. Six complaints were made by patients and relatives to the local complaints appeals manager at St Finan's during 2000 and all appeared to have been dealt with

satisfactorily. There were ninety-six accidents to patients and twenty-four accidents to staff in St Finan's in 2000 and none were deemed serious. There were two recorded assaults on patients and twenty recorded assaults on staff; two of the staff assaults required further medical intervention. A recording system should be in place at Tralee General Hospital to record accidents and assaults to patients and staff and any untoward incidents. There should also be regular scrutiny of statistics by unit managers to provide analyses by time of day, geographical location, cause of accident, incident or assault and nature of injury. The number of occupational therapists, social workers and psychologists needed to be augmented to provide true multidisciplinary teams in each sector.

Prescription cards at a number of locations were examined. The written drugs policy and procedure was under review at the time of inspection. The legibility of individual prescriptions varied. Some were excellent with a low risk of drug error. All prescriptions required the full signature and date for each individual prescription. Discontinued drugs should be signed off using the discontinuation column. There was an increased risk of error in a number of prescription cards where the number of discontinued prescriptions was greater than that of current prescriptions. Some individual prescriptions were dated 1999 and needed to be reviewed and rewritten. A copy of the current drugs procedure and policy was not available at the time of inspection in the unit at Tralee General Hospital.

The admission notes on individual clinical files examined were satisfactory. However, it was noted that the clinical notes contained a special form for physical examinations and this was not completed although the physical examination was recorded within the clinical notes. In general, the notes were legible and easy to follow but it was suggested that all entries should have the full signature of the professional staff making the entry. Ideally, doctors should write their name in capitals, sign the entry and record their designation to ensure easy identification of the practitioner. While the date of the entry was recorded, it was recommended the time of entry also be recorded as it was useful in determining any delays in assessment or treatment. The patient's name and personal number was not always noted on each continuation page, thus making it difficult to determine if the information was pertinent to the record under review. Copies of discharge letters were readily accessible within the notes. They contained a summary of all relevant information and follow-up arrangements, including diagnosis and prognosis. The discharge diagnosis was clearly stated in the medical notes, as were follow-up plans. Investigations were filed correctly, as was the correspondence within the notes examined. There was a considerable collection of loose clinical material in an open pocket at the back of many files. There were certain risks associated with unsecured contents e.g., misfiled information and delays in accessing pertinent information when required.

At the time of inspection, the hospital management were reviewing and updating operational policies and procedures in accordance with service needs and current good practice. This was welcomed. Revised policy statements would be based on clinical administrative practice and research and would be designed to assist staff make decisions about clinical and administrative matters relating to the appropriate care of patients and the needs of staff providing that care.

A number of patients at the acute unit in Tralee General Hospital were asked for their views on the service provided in order to highlight areas where the local service needed to make changes in response to patients' wishes or to inform local services of general satisfaction with the services provided. All patients were satisfied with the courtesy and helpfulness of staff and with the admission process. All knew the name of their consultant psychiatrist and all reported having adequate access to them while hospitalised. They were informed about the nature of their medical condition and understood what was explained to them. Two patients were not aware of their rights under the Mental Treatment Act, 1945 or on how to make a complaint if they felt aggrieved. Patients were generally satisfied with all aspects of privacy and dignity relating to their care, facilities for visitors, access to and cleanliness of the toilets and bathrooms, and sleeping arrangements. Two patients expressed dissatisfaction with the quality of food provided and indicated that meals appeared to be re-heated and consequently lacked flavour. All patients reported having adequate storage space for clothing and personal possessions and were aware of facilities on the ward to wash personal clothing. Two patients expressed a dislike for the locking of the external ward door. When asked what should be done to improve a patient's stay in hospital, one patient suggested providing a rack for newspapers, another suggested access to a gymnasium and access to a larger smoking room.

RECOMMENDATIONS

It is recommended that:

1. Sector headquarters be provided for North and South Kerry, with adequate day hospital provision in Killarney.
2. A sector headquarters and day hospital be provided in Listowel.
3. A consultant-led psychiatry of later life service be established within the catchment area.
4. Further community residential premises be acquired for patients from St Finan's Hospital.
5. St Denis's and St Bernadette's locked wards be closed as soon as possible and serious consideration be given to the local services plan to provide appropriate facilities at Cherryfield or at Ross and Mangerton for this vulnerable group of patients.
6. The O'Connor Unit be de-designated and integrated into the care services for older people.
7. Serious decisions be made on the future use of the vast amount of empty space in St Finan's Hospital.
8. An emergency resuscitation trolley be provided in Our Lady's Ward, St Finan's Hospital; the ward itself be upgraded, particularly the bathrooms, and appropriate facilities be provided for the care of the dying.

NORTH CORK MENTAL HEALTH SERVICE — 2001 INSPECTION

INSPECTED ON 2 JULY, 2001

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 75,690 was divided into three sectors as follows:—

Sector	Population
Fermoy	25,783
Mallow	26,012
Kanturk	23,895

IN-PATIENT CARE

In-patient care was provided at St Stephen's Hospital, Glanmire which provided 216 beds in nine integrated wards.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	10	14	6	3	33	15.21
3-12 Months	—	—	6	2	3	3	14	6.45
1-5 Years	—	—	4	7	9	6	26	11.98
> 5 Years	—	—	6	52	44	42	144	66.36
All Lengths of Stay	—	—	26	75	62	54	217	100
% of Total	—	—	11.98	34.56	28.57	24.89	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
14	119	—	41	7	1
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
7	8	—	16	4	217

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	125	67	192
Temporary	9	9	18
P.U.M.	—	—	—
Ward of Court	3	4	7
Total	137	80	217

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 523
Number of first admissions in 2000 157
Number of discharges in 2000 527
Number of deaths in 2000 11

Legal status of admissions
Voluntary 95%
Non-voluntary 5%

The number of admissions represented an admission rate of 6.9 per 1,000 of the catchment population. First admissions accounted for thirty per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	25	104
Day Centres	3	44	117
Out-patient clinics	6	170*	1,041

*No. of out-patient clinics held in 2000

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
3	12	—	—	1	14

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
9.33	19.66	184.5	68.17	6.33

COST

The cost of the North Cork Mental Health Service was £12.2 (€15.5)m in 2000 which reflects the cost of caring for patients outside the catchment area and the costs of the dementia unit.

GENERAL COMMENTS

Unfortunately, there had been little development or progress in this service since the previous inspection. Thus, the community services were still rudimentary, the latest initiative being the provision of a high-support residence in Mallow to complement the day centre which opened in 2000. There were, however, plans to establish a consultant-led rehabilitation service to deal with the problem of existing long-stay patients in St Stephen's. It was hoped to extend the psychology services and an additional occupational therapist had been recruited to the service. An advertisement for a principal social worker had been placed in early June 2001, and the social worker was due to commence duty at the beginning of 2002. A commitment had been made by the Board to develop a later life

psychiatry service for North Cork and funding approval had been sought for the consultant-led team.

Despite the lack of new community developments in 2000, a number of initiatives were planned. St Pancras Housing Organisation, a voluntary body, had worked with the North Cork service in planning a fourteen-bed housing project and day hospital/day centre premises in Fermoy. It was hoped that this welcome initiative would be completed by September 2002. A house had been purchased in Charleville to serve as a day centre. The Mental Health Association was actively pursuing the provision of a twenty-four hour supervised residence in Kanturk and proposals to extend the day centre in Mitchelstown were at an advanced stage. It was also hoped to extend and improve the day centre in Kanturk. The Board was also in the process of purchasing land in Kanturk for the provision of a housing project and a number of independent flatlets.

There were over 200 patients from all four Cork catchment area services in St Stephen's Hospital. Most of the patients had been hospitalised for many years which made active rehabilitation an urgent requirement. Therefore, the commitment to providing a rehabilitation team was welcomed. A patient survey had been carried out to establish the extent of their rehabilitation needs. Of 176 patients surveyed, fifty-four were identified as suitable for immediate community placement and 122 were deemed in need of preparatory rehabilitation inputs prior to placement. Seventy-six patients came from North Lee, forty-six from North Cork, thirty-four from West Cork and twenty from South Lee. All of the non-North Cork patients appeared to be no longer in touch with their original catchment area teams. This obviously created problems from an administrative, clinical and rehabilitation point of view. It should, therefore, be a task of the rehabilitation consultant to re-involve the relevant teams in the process of rehabilitation to community placement, which should be a joint undertaking between them and the specialised rehabilitation team. It should also be the case that no further patients transfer to continuing care in St Stephen's except those from North Cork teams. It was felt that the two admission units, one of which had reduced its capacity from twenty-two to thirteen patients in the past year or so, might be amalgamated in the context of a more formal and rigidly-applied admission policy, even though the lack of community facilities, particularly day hospital structures, reduced alternatives to acute in-patient care.

The mix of patients with intellectual disability and enduring disabling illness in Unit 5 was noted. This unit was being refurbished and a garden facility added. The dozen or so patients currently in the unit were being dispersed to other locations in St Stephen's as a temporary measure. Attempts were being made to move patients with intellectual disability from Unit 5 and other areas of the hospital to more appropriate and specialised facilities elsewhere in the Board area and this initiative was welcomed. The Board expected that Unit 5 would become an active rehabilitation unit as part of the overall rehabilitation provision in the service. The impending de-designation of Unit 2 and its absorption into a wider service for older persons was also welcomed.

There were 226 occupied beds in St Stephen's Hospital on the day of inspection. Thirteen patients were hospitalised on temporary certificates; ten were Wards of Court. There were

forty-four episodes of special one-to-one nursing supervision involving forty patients in St Stephen's in 2000. A written policy and procedure relating to special nursing supervision was available in clinical areas for staff information. Seclusion was not used in this service. The service had access to the intensive care facilities at St Kevin's Block, Our Lady's Hospital. Four patients from St Stephen's were transferred there for short periods during 2000. There were forty-nine episodes of ECT at the hospital during the year involving seven patients. A dedicated waiting room and an ECT treatment room with a shared recovery area were provided. Documentary procedures relating to the administration of ECT were satisfactory.

Two patients under sixteen years of age were admitted to St Stephen's Hospital in 2000, both with depressive disorders. Sixteen patients had their temporary admission orders extended during the year. Statistics on the number of patients discharging themselves from the hospital against medical advice was not available at the time of inspection. There were ten recorded complaints/appeals by patients and relatives to the local Complaints/Appeals manager in 2000 and all appeared to have been dealt with satisfactorily. A total of 276 accidents to patients and sixteen accidents to staff were recorded in the same year. One accident to a patient was deemed serious. There were thirty-six recorded assaults on patients by other patients and eighteen recorded assaults on staff; none were deemed serious.

The written policy on ordering, prescribing, storing and administering medical preparations was not dated. The medical preparations policy should be signed and dated with an appropriate review date and should contain information on staff responsibility in relation to ordering drugs, storing and checking drugs stocks, administering drugs and information on drugs given to patients on discharge. Written instructions on the use of prescription cards should be included within the policy manual. A number of individual prescriptions from various locations throughout St Stephen's Hospital were examined and overall standards varied. Some prescriptions were blocked and not scripted. Others were scripted but were easy to read. All prescriptions should have one date and one full signature. Some of the signatures were illegible. There was an increased risk of error if the number of discontinued prescriptions exceeded current prescriptions. Discontinued drugs should be signed off using the discontinuation column. Some prescriptions were dated 1996, 1997, 1998 and 1999. All needed to be reviewed and updated. There should be provision for recording a nurse's signature on the drug administration card. Emergency drug trays were available in ward areas. These were checked each week and appropriate records were kept. This was satisfactory.

There was an induction process for all new staff and appropriate records were kept. All staff had the opportunity to participate in CPR training and other courses such as safe lifting/manual handling of loads and the management of aggression and violence. Records were kept of all training programmes. Several nursing records were examined at various locations throughout the hospital. The quality of content varied. The progress records did not always refer to the plans and intervention goals relating to the nursing assessment. It was suggested that nursing records be audited to assess standards of record-keeping and to identify areas for improvement in staff training, especially in long-stay wards. The

records should reflect the involvement of patients in planning and making decisions about their care and treatment. The evaluation of nursing care plans should include patients' views about their progress, any negotiated changes in the plans and the results of such changes. All entries in the nursing notes were dated accurately and signed in full and the patient's name, date of birth and address were recorded appropriately. Abbreviations were not apparent in the notes examined and the notes identified everyday problems that had arisen and actions taken to rectify them.

The safety statement from the hospital and local units adhering to standards and procedures set by the Safety and Welfare at Work Act, 1989 was dated 1995. There was a safety committee, with an identifiable safety officer, which met four times per year. It was recommended that the safety statements for the hospital and the local areas be reviewed and updated. Safety statements and records of safety audits pertinent to each local area should be available locally as well as centrally to ensure that staff followed up on the identified risks.

A number of medical records were examined. Each record had space for the patient's name on the outer cover which enabled easy identification. The record folder had an open pocket on the inside rear cover which contained a number of investigation reports and other loose clinical material in a number of files. Risks associated with the use of pockets included delay in accessing pertinent information and lost or misfiled information as the contents were not secure. No instructions were provided on the filing of documentation within the record. The medical records of one long-stay patient examined had an input dated 30 June, 2000 and the next inputs were dated 30 June, 2001 and 1 July, 2001. This was unsatisfactory.

Medical notes in the admission units were generally satisfactory. The final diagnosis was recorded clearly and unambiguously within the notes. The notes were reasonably legible and easy to follow. The history of presenting complaint, past history, personal history, family history, mental state examination, physical examination, current medication, summary and clear immediate management plan were all appropriately recorded. In a small number of files, the signature of the doctor was illegible. Designation was not always recorded. Ideally, the professional should write his or her name in capitals, sign the entry and record his or her designation to ensure easier identification of the practitioner in future. Entries recorded the date of entry but not the time. Recording the time was useful to determine any delays in assessment or treatment. The patient's name and identification number should be recorded on each continuation sheet. Several files of recently-discharged patients were examined. Discharge diagnosis and follow-up plans were clearly stated in the medical notes. Discharge letters were easily accessible and contained information on diagnosis, medication on discharge, summary of all relevant information and follow-up plans.

A number of patients in the admission units were interviewed to ascertain their views on the care they received. Patients were generally satisfied with the admission process and the courtesy and helpfulness of staff. They knew the name of their consultant psychiatrist and reported having access to them twice weekly or more often if required. Patients

reported being informed about the nature of their medical condition and having an understanding of what was explained to them. They were aware of their legal status while hospitalised, except one patient who was not aware of his rights under the Mental Treatment Act, 1945 or on how to make a complaint if he felt aggrieved. Other patients reported seeing information on the complaints procedure in the hospital booklets. All patients were satisfied with the quality of food provided. One patient from North Cork referred to the long travelling distance for visitors from her home. She suggested a new admission unit more easily accessible to patients from North Cork. The patient referred to a shortage of beds and having to move beds into the recreation room. This resulted in a loss of belongings on occasions when the unit was overcrowded. The male patients interviewed were satisfied with the cleanliness of the toilets and bathrooms. Female patients referred to the old-fashioned cistern in the female toilets and difficulties flushing the toilets. All patients were happy that they had access to a bath or shower when requested.

Patients felt they had adequate storage space for personal belongings and facilities to wash personal clothing. They expressed satisfaction with access to nursing staff and knew the name of the primary nurse assigned to them. Patients reported finding the day in the admission facility long and boring and would benefit from access to occupational therapy. It should be noted that patients had access to occupational therapy and good use was generally made of this facility. They referred to the fact that the sitting/television room in the admission area became overcrowded at times and the positioning of the television made it difficult for them to view it in comfort. One patient indicated that illegal drugs were being used on the wards, but was unsure whether they were easily available to patients. Other patients had no knowledge of this. All patients reported ready access to the telephone and to fresh air when required. Patients were satisfied that they were actively involved in all decisions affecting their care and were satisfied with the care provided. One patient expressed a dislike of having to repeat information to different professionals, as it was 'reliving the situation'. All patients expressed satisfaction at the information given to them in relation to their prescribed medication and its long- and short-term affects. Patients interviewed had been hospitalised in St Stephen's on previous occasions and all referred to the major improvement in the decor and the ward atmosphere. The new curtains, blinds and improvements in the male toilet facilities were particularly welcomed.

RECOMMENDATIONS

It is recommended that:—

1. An acute admission unit for the North Cork Mental Health service be provided at Mallow General Hospital.
2. Sector-based community facilities be developed in the service.
3. A specialised consultant-led intensive care team be put in place as soon as possible.
4. A specialised rehabilitation service be put in place without delay.
5. Admission facilities at St Stephen's Hospital be rationalised in conjunction with improved and formalised admission policies.

6. A specialised service for later life psychiatry be put in place, not least because of the substantial number of older patients in St Stephen's.

NORTH LEE MENTAL HEALTH SERVICE — 2001 INSPECTION

INSPECTED ON 3 JULY, 2001

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 144,522 was divided into five sectors as follows:—

Sector	Population
City North East	26,335
City North West	30,432
Macroom/Blarney	29,802
Cobh/Glenville	30,017
Midleton/Youghal	27,936

IN-PATIENT CARE

In-patient care was provided at Our Lady's Hospital where one male, one female and one integrated unit provided fifty beds and at St Michael's fifty-bed acute psychiatric unit, the Mercy Hospital. The Owenacurra Centre, Midleton also provided thirty-six beds.

Age and Length of Stay of all Patients at 31.12.00

Age **Length of Stay**	**<15**	**15-19**	**20-44**	**45-64**	**65-74**	**>75**	**All Ages**	**% of Total**
< 3 Months	—	5	33	18	2	4	62	45.25
3-12 Months	—	—	5	2	—	—	7	5.11
1-5 Years	—	—	8	10	5	2	25	18.25
> 5 Years	—	—	3	18	15	7	43	31.39
All Lengths of Stay	—	5	49	48	22	13	137	100
% of Total	—	3.65	35.77	35.04	16.06	9.48	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	**Schizophrenia**	**Other Psychosis**	**Depressive Disorders**	**Mania**	**Neurosis**
2	48	—	62	7	1
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
7	4	1	3	2	137

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	58	46	104
Temporary	19	11	30
P.U.M.	1	—	1
Ward of Court	2	—	2
Total	80	57	137

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 1,044
Number of first admissions in 2000 359
Number of discharges in 2000 1,042
Number of deaths in 2000.....0

Legal status of admissions
Voluntary.....79.1%
Non-voluntary 20.9%

The number of admissions represented an admission rate of 7.2 per 1,000 of the catchment population. First admissions accounted for over thirty-four per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	2	40	163
Day Centres	2	50	55+
Out-patient clinics	9	626*	1,528

*No. of out-patient clinics held in 2000

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
3	16	2	13	3	48

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
16	12	160.78	49.06	7

COST

The cost of the North Lee Mental Health Service was £8.1 (€10.3) million in 2000.

GENERAL COMMENTS

Considerable thought and imagination had been invoked in this service to provide five self-sufficient and structurally sound sector services served by multi-disciplinary teams. It was hoped that the planned initiatives and developments would be put in place as quickly

as possible. In addition, the psychiatric unit for acute care in the Mercy Hospital was functioning for over a year and had greatly improved this component of the service compared to previous arrangements in St Anne's. However, there were some reservations about the physical layout of St Michael's. Some of these sentiments were shared by the service providers themselves but, overall, this was a high-class unit. The security arrangements at its entrance were somewhat off-putting and intimidating, but there were plans to find alternative solutions to the unit's first-floor entrance. There had been considerable pressure on beds but it was understood that a codified admissions policy, which would contribute as far as possible to the conduct of clinical assessments away from the unit in community bases and the confinement of admission decisions to consultants, would significantly improve matters.

Plans by the Southern Health Board to establish a consultant-led psychiatric programme for the homeless with a full multi-disciplinary team working closely with the Simon Community was welcomed. The service was strengthened by the addition of five new community psychiatric nurses, one for each sector. In addition, funding had been provided for two psychologists, a social worker and an occupational therapist. The opening of the fifteen-bed high-support residence at Millfield House, Blackpool and its adjoining day centre was welcomed. Accommodation was of a high standard. The new day centre at Innis Carraig House was set to open shortly after the inspection and would make a significant contribution to service provision.

Three wards in St Kevin's Block, Our Lady's Hospital remained open. The first was a long-stay ward with patients from the North Cork service who required rehabilitation. The other two wards comprised intensive care units, one acute and the other for longer-stay patients with considerable symptomatic and behavioural morbidity. The acute unit catered for 220 admissions in 2000. This large number of admissions was a consequence of the inability of catchment area services to manage their more seriously ill patients, partially because of the inadequate facilities in their acute admission units. The Inspectorate had mentioned the totally unacceptable physical conditions prevailing in St Kevin's in the past and was happy to hear that St Anne's, the former admission building, would be ready to take forty patients from St Kevin's in autumn 2001. The three wards would then reduce to two, one for intensive care and the other for rehabilitation purposes at this newly upgraded location.

The Inspectorate strongly endorsed the view of service providers that the intensive care service should be a specialised one with a dedicated consultant-led team to replace the current unsatisfactory situation where the intensive care wards were managed on an annual rotation between the constituent catchment area teams. It was felt that this team and function should be independent of, but related to, the forensic team and function. The establishment of the appropriate relationship between the two should be a matter of full and sensitive differentiation on the one hand and co-operation on the other.

There were nine episodes of seclusion involving eight patients in Our Lady's Hospital in 2000. A new seclusion policy and procedure was under consideration and a draft copy was available on this inspection. The seclusion policy included extracts from the Mental

Treatment Act, 1945 and covered authorisation for seclusion, where seclusion was to take place, observation of patients and care reviews, records of seclusion, patients' rights, rights of nearest relatives, common nursing responsibility for patients placed on seclusion and a summary of the seclusion procedure. The document also included information on alternate uses of the seclusion room and the provision of a safe environment. Commencement forms containing a patient's name, address, date of birth, time seclusion commenced, duration of seclusion, reason for seclusion and an assessment of the overall effect of seclusion with appropriate care reviews were also included in the policy and procedure document. All of this was comprehensive and satisfactory.

The North Lee Mental Health Service had introduced new procedures in relation to the administration of ECT. Documentation included the consent form, ECT prescription and treatment form, pre-ECT medical check list and pre- and post-ECT nursing checklist. All of these new or updated documentary procedures were satisfactory. Eight patients were prescribed ECT in 2000.

Four persons sixteen years or under were admitted to the psychiatric service in 2000, all with depressive disorders and three patients discharged themselves from in-patient care against medical advice. Eight patients had their temporary admission orders extended during the year. Only one complaint was made to the local complaints/appeals manager during 2000. One assault on a patient by another patient and five assaults on staff were recorded; none were deemed serious. Seven accidents to staff were recorded in 2000. Information relating to accidents and incidents to patients was not available at the time of inspection, assurances were given that such matters were appropriately recorded. An auditing system should be established for tracking and trending accidents, incidents and assaults by date, time and location.

A number of nursing records were examined. The 'Roper Model' of nursing care was used in St Michael's Unit. The primary nurse care system was also in operation and was prominently displayed on the ward notice board. Records examined confirmed that patients appeared to settle into the ward at the end of their first day. Entries in the nursing records were made as soon as possible after events to which they related. The records appeared to identify problems that had arisen and actions taken to rectify them. While all records were dated accurately, it was suggested that the time of entry should also be recorded. The full signature of the nurse making the entry was noted in all of the records examined. There was need for a greater correlation between the goals and nursing interventions and the nursing notes. It was suggested that the standard of record-keeping be audited to assess and identify areas for improvement. In particular, nursing records should reflect the involvement of patients in planning and making decisions about their own care and treatment and subsequent evaluation of care plans should include patients' views about progress.

A number of prescription cards were examined at the Mercy Hospital and at St Kevin's Block, Our Lady's Hospital. Prescriptions were scripted but were not difficult to read. Drug allergies were recorded in the nursing kardex and were readily available to staff. There was an increased risk of drug error where discontinued prescriptions were greater

in number than current prescriptions, as was the case in a number of cards examined. Discontinued drugs should always be signed off using the discontinuation column, which should include the date and full signature of the doctor. Similarly, all prescriptions should be dated individually and signed in full. Many of the prescriptions examined met these standards. There should be an internal audit system to ensure total compliance with the required standard. Patients prescribed Clozaril or lithium were given information about their medication and treatment. No other written information on prescribed drugs was available for patients.

A number of clinical files were examined. Written instructions on filing documentation within the medical records were required. Pathways to admission, history of presenting complaint and mental state examination were well documented. However, on one of the clinical records examined, no record of past, personal or family details and no evidence of a physical examination on admission was found. A clear summary of the case was not documented and there appeared to be no immediate management plan. Progress notes on the file provided a reasonable account of the illness and explained clinical decisions. There was a need to record the patient's name on each continuation page of the medical notes. Inputs from psychologists, psychiatric social workers, occupational therapists and others were not observed in the files examined.

A number of patients in St Michael's Unit were interviewed to ascertain their views on the level of care provided. Patients were satisfied that they had reasonable access to services. They knew the name of their consultant psychiatrist and reported having access to them twice weekly while hospitalised. Patients were informed about the nature of their medical condition and the medication prescribed to them but one patient indicated that it took some time for her to understand what was explained. Another did not understand the explanation as it was too technical. Patients were aware of their legal status while hospitalised but were not aware of their rights under the Mental Treatment Act, 1945 or on how to make a complaint if they felt aggrieved. All patients were satisfied with the quality and quantity of food provided and with all aspects of dignity and privacy relating to their care. Patients were satisfied with the courtesy and helpfulness of staff although one patient felt the staff 'ignored her physical complaints'. One patient near the nurses' station reported difficulty in getting a good night's sleep as she could overhear the staff conversing. While patients were satisfied that they had adequate storage space for clothing and personal belongings, they expressed dissatisfaction at the lack of facilities for washing personal clothing. They generally were satisfied with the ward environment and decor but disliked the 'locked door'. Most welcomed access to the occupational therapy department and expressed general satisfaction with the range of activities available. Some patients reported a lack of nursing continuity as the nurses changed daily. All patients reported easy access to telephones. One patient would have liked more opportunity to talk with the doctors and nurses. Patients were generally satisfied that the service providers had involved them in all decisions affecting their care.

Appropriate training programmes should be introduced for patients in long-stay wards, community residences and day centres to familiarise them with the new Euro currency.

Press-out pictures of Euro notes and coins were available from the Euro Changeover Board of Ireland. Preparation of patients would help them make the change with as little stress as possible.

RECOMMENDATIONS

It is recommended that:—

1. Plans to move patients to St Anne's facility be expedited as the wards in St Kevin's were unacceptable.
2. The Owenacurra Centre in Midleton be de-designated.
3. Access to open space and fresh air be provided for patients at St Michael's Unit.
4. Additional sector structures and personnel be provided in some sectors of the catchment area, i.e. Cobh/Glenville, Youghal, and City North East/Mayfield.
5. Information on patients' rights under the Mental Treatment Act, 1945 and amending legislation be readily available to all hospitalised patients.
6. Alternative solutions for public access to St Michael's Admission Unit be explored.

SOUTH LEE MENTAL HEALTH SERVICE — 2001 INSPECTION

INSPECTED ON 3 JULY, 2001

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 156,430 was notionally divided into five sectors as follows:—

Sector	Population
City South-West	27,134
City South-East	28,390
Douglas/Carrigaline	38,444
Bandon/Kinsale	26,066
Bishopstown/Ballincollig	36,396

IN-PATIENT CARE

In-patient care was provided at the forty-six bed Acute Unit GF, Cork University Hospital (CUH) and in two long-stay psychiatric units at St Finbarr's Hospital which provided forty-four beds.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	3	14	13	9	1	40	48.19
3-12 Months	—	—	5	1	—	—	6	7.23
1-5 Years	—	—	—	11	1	—	12	14.46
> 5 Years	—	—	10	5	7	3	25	30.12
All Lengths of Stay	—	3	29	30	17	4	83	100
% of Total	—	3.61	34.94	36.15	20.48	4.82	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
1	35	7	17	6	5
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
3	4	3	2	—	83

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	32	40	72
Temporary	8	4	12
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	40	44	84

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 688
Number of first admissions in 2000 221
Number of discharges in 2000 690
Number of deaths in 2000 2

Legal status of admissions
Voluntary 77.9%
Non-voluntary 22.1%

The number of admissions represented an admission rate of 4.4 per 1,000 of the catchment population. First admissions accounted for thirty-two per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	25	109
Day Centres	1	15	96
Out-patient clinics	4	560*	1,839

*No. of out-patient clinics held in 2000

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
5	15	1	6	2	20

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
14.5	3	75.66	9.51	1.97

COST

The cost of the South Lee Mental Health Service was £3.6 (€4.6) million in 2000.

GENERAL COMMENTS

The South Lee Mental Health service had been divided into six sectors earlier in the year. Unfortunately, there was little community services provision in any of the sectors apart from the Ravenscourt day hospital and the Ballincollig day centre which was due to open in October/November, 2001. Staff in the service were unhappy with the failure of the service to acquire premises in the sectors to provide day hospitals, sector headquarters and community mental health centres. Staff claimed to have identified suitable premises in some of the sectors for some of these functions but had not been able to persuade management to acquire these premises. As a result, there had been little opportunity to provide alternatives to hospitalisation and out-patient clinics and bed capacity in the forty-six-bed unit was always stretched.

Unit GF in Cork University Hospital badly needed to be remodelled as it was both unsuitable for the care of acutely disturbed patients (largely due to a lack of observation facilities) and because space for the various professionals and others working in the unit was inadequate. Despite this, a very high percentage of patients exhibiting disturbed behaviour were successfully nursed and contained in Unit GF. In addition, the therapy area in the portacabin building was unsatisfactory and appropriate accommodation should be provided. Other difficulties included the provision of assessment beds and an adjoining day hospital facility for the psychiatry of later life service. A professional infrastructure of psychologists, social workers, occupational therapists and additional community nurses was needed to sustain such a service. There were only four community nurses working in the service, whereas an adequate provision would be two nurses per sector. No occupational therapists were employed and efforts to recruit them were being made. Efforts to augment social work and psychology services were also being made. An additional consultant liaison psychiatrist post in Cork University Hospital had been approved and was to be advertised shortly after the inspection. It was also hoped to recruit a part-time psychiatrist to deal with the psychiatry of the homeless who could also avail of the services of the rehabilitation consultant-led team for the rehabilitation of patients from this service,

including those from St Stephen's Hospital. The designation of one staff member to act in the field of consumer relations was welcomed.

There were 734 spans of special one-to-one nursing supervision involving thirty-six patients at Cork University Hospital in 2000. Seclusion was not used but the service had access to St Kevin's intensive care unit at Our Lady's Hospital. Forty-two patients transferred from Unit GF to Our Lady's Hospital and twenty-five patients discharged themselves from the psychiatric unit against medical advice in 2000. Follow-up procedures were available in cases of patients taking their own discharge, if considered clinically appropriate. No complaints were made to the local complaints/appeals manager during the year. Twenty-seven accidents to patients and three accidents to staff were recorded during 2000. Two assaults on patients by other patients and eight assaults on staff were recorded. None of the accidents or assaults were deemed serious.

A number of clinical files were examined. The admission notes were satisfactory and included documentary records of pathways to admission, mental state examination, physical examination, personal, past and family history, history of presenting complaint and clear immediate management plan. The notes themselves were relatively easy to follow and progress notes provided a chronological account of the illness. All entries in the medical notes should contain the full signature and designation of the professional making the entry to ensure easy future identification. While the date of entries was appropriately recorded, the time of entry should also be noted and the patient's name recorded on each continuation page. Discharge letters were available within the clinical file. The discharge note, completed in triplicate, contained information about medication on discharge, a summary of relevant information and follow-up arrangements. One copy of the note was given to the patient, one to the doctor responsible for follow-up care and one retained on the patient's file. A comprehensive medical report ensued within one week of discharge. Investigation reports were correctly filed within the medical file. However, loose clinical material was stored in a pocket on the file. This practice could cause difficulties in accessing pertinent information or the loss of important clinical information. Inputs from psychologists, social workers and occupational therapists should be appropriately recorded and should form an integral part of the clinical file.

Nursing records were examined and an appropriate model of nursing was in use. An evaluation group was looking at the nursing documentation with a view to introducing a more modern and comprehensive nurse care planning system. Existing care plans were reviewed weekly or more often if necessary. There was a need for greater correlation between the care plans and the nursing notes. The nursing records confirmed that patients appeared to settle well into the ward at the end of the first day of hospitalisation and also that patients were given a chance to talk about their fears about admission. The records identified problems that had arisen and the action taken to rectify them. All entries were accurately dated and signed in full. Block lettering alongside the signature of the first entry should be considered.

There was a written drugs policy and procedure which was dated 1999. All policies and procedures were under review. The prescriptions examined were all scripted but were not

difficult to read. However, it was suggested that all prescriptions should be signed in full and dated individually. Similarly, discontinued drugs should be signed off in full using the discontinuation column. There was an increased risk factor if discontinued prescriptions were greater in number than current prescriptions, as was the case in a number of cards examined. Prescribed medication was appropriately recorded in case notes. Some of the doctors' signatures on the prescription cards were illegible and this required review. Information was given, on request, to patients about their medication and treatment in the form of information leaflets from pharmaceutical companies.

Patients at Unit GF were interviewed to ascertain their views on the level of service provided. Those questioned were generally satisfied with the courtesy and helpfulness of staff, knew the name of the consultant psychiatrist and had access to them twice weekly. They were satisfied with the quality and quantity of food provided and with all aspects of privacy and dignity relating to their care. The toilets, bathrooms and sleeping areas were described as adequate. One patient requested an additional shower unit. Patients were not aware of their rights under the Mental Treatment Act, 1945 and amending legislation or on how to make a complaint they felt aggrieved. Patients knew that an information booklet on service provision was available but had not read it. Patients were satisfied with storage for clothing and personal belongings but requested facilities to wash their clothes. With the exception of the unsatisfactory portacabin, which was also used as a smoking room, patients were generally satisfied with the ward environment and decor. One patient particularly liked the new water fountain feature within the ward. Another reported enjoying the woodwork sessions but requested more access to occupational therapy and a greater variety of activities. Other patients were satisfied with the activities available.

Patients knew the name of their primary nurse and reported having adequate contact with nursing staff while hospitalised. All patients expressed general satisfaction with access to telephones and fresh air. One patient requested that the local clergy visit more often and engage in conversation with patients. They were satisfied with the care they were receiving in Unit GF and felt the professional team actively involved them in their own care and treatment. All reported having being informed about the prescribed medication and its long- and short-term effects. Some patients would like to receive written information on prescribed drugs. Patients commented favourably on the general improvement in the overall ward environment, the modern furnishing, pictures, flowers and, in particular, the emphasis on the part of the staff on 'giving patients more information and sharing more with patients'.

RECOMMENDATIONS

It is recommended that:—

1. Funding be made available to set up the necessary community infrastructure for this service and that this be done as soon as possible.
2. The existing portacabin at Unit GF, University College Hospital, Cork be replaced with an appropriate structure.
3. The necessary alterations to improve observation in Unit GF be undertaken as soon as possible.

WEST CORK MENTAL HEALTH SERVICE — 2001 INSPECTION

INSPECTED ON 5 JULY, 2001

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 48,000 was divided into two sectors as follows:—

Sector	Population
Skibbereen/Clonakilty	21,000
Bantry/Dunmanway/Schull/Castletownbere	27,000

IN-PATIENT CARE

In-patient care was provided at the eighteen-bed psychiatric unit, Bantry General Hospital.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	2	7	1	1	11	91.67
3-12 Months	—	—	1	—	—	—	1	8.33
1-5 Years	—	—	—	—	—	—	—	—
> 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	—	3	7	1	1	12	100
% of Total	—	—	25.00	58.34	8.33	8.33	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	6	—	3	—	—
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
1	2	—	—	—	12

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	6	4	10
Temporary	2	—	2
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	8	4	12

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 349
Number of first admissions in 2000 104
Number of discharges in 2000 361
Number of deaths in 2000 1

Legal status of admissions
Voluntary 93.7%
Non-voluntary 6.3%

The number of admissions represented an admission rate of 7.3 per 1,000 of the catchment population. First admissions accounted for thirty per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	—	—	—
Day Centres	1.2	43	25
Out-patient clinics	7	135*	998

*No. of out-patient clinics held in 2000

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
5	25	3	29	1	28

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
6	2	21	13	3.5

COST

The cost of the West Cork Mental Health Service was £2.8 (€3.6) million in 2000.

GENERAL COMMENTS

The West Cork service comprised two sectors, each of which was consultant-led. For several months prior to the inspection, there had been only one temporary consultant in the service. However, one permanent appointment had been made from a recent competition and the successful candidate was due to take up the post shortly after the inspection. There were five nursing vacancies in the service. There were four NCHD posts but only three were filled. One occupational therapist, one social worker and one part-time psychologist were also employed in the service.

Providing a comprehensive mental health service in a catchment area as thinly populated and widely dispersed as West Cork was a challenging task. The distance of about sixty miles over indifferent roads from the extreme eastern end of Clonakilty to the Atlantic

Ocean in the west was, in the eyes of the local service providers, compounded by a possible extension further eastwards to take in the area around Timoleague. The difficulties were not helped by the absence of day hospital facilities and limited day centre provision in the catchment area. However, there were plans to provide day hospital/day centre facilities in Bantry and, possibly, Skibbereen. There was a sector headquarters in Skibbereen, based in the same premises (Perrott House), as a twenty-eight bed high-support residence. However, only the community nursing component of the multidisciplinary team was based in the headquarters and worked from it. Medical presence was limited to sessional visitations to provide out-patient clinics. Similar arrangements applied to social work and psychology services.

A feature of this service for some years had been the fact that some patients from the catchment area were admitted directly to Our Lady's Hospital, Cork, often without the West Cork Service being aware of it. This happened because the patients were brought there directly by Gardai on PUM certificates or because the local service judged that they should go there directly. More worrying was the discharge of these patients back into the catchment area without notifying the West Cork team. This, potentially at least, could result in no follow-up arrangements being made for their subsequent care. This practice, if not completely abolished, should be greatly curtailed. For this purpose, the provision of a secure room in the unit at Bantry should be considered. Patients perceived as being difficult to manage were often placed on special one-to-one nursing supervision but additional back-up of a secure room should be provided. This would be far preferable from a clinical and humanitarian point of view than having patients from the catchment area transported, under Garda escort, from the catchment area to Our Lady's Hospital, Cork.

A crucial issue for a service of such small size and relative isolation was the provision of specialist services and it was clear that the lack of child and adolescent services, or easy access to them, was a hampering factor for the service. As matters stood, there had been a number of admissions of children under sixteen years of age to the Bantry unit. Needless to say, this was an undesirable practice. Similarly, the difficulties of providing a dedicated later-life psychiatric service were evident. Alcohol counselling services were not available either, although a staff member was undertaking training in Cork city. A greater skill mix among nursing staff was desirable. The replacement of some nursing posts and activities by non-nursing staff, with the freeing up of nursing staff to be trained for the practice of more specialised inputs, would be desirable.

Some interesting developments and initiatives were proposed for this service. The Mental Health Association of Ireland was drawing up plans for submission to the Department of the Environment for grant aid to provide a comprehensive residential facility on a site adjacent to Bantry Hospital. When this venture was completed, it would accommodate the patients from the Dromleigh residence and free up the three buildings there for use as a day hospital/day centre. A house just opposite this proposed development had been purchased and renovated by the Board and a planning application to extend the premises had been made. Once this was granted, the single-storey premises would provide accommodation for persons in the Cois Cuan residence in Bantry, many of whom were older

persons. When they moved to the new residence, the Cois Cuan places would be filled by younger, more active residents. £500,000 (€635,000) was available to upgrade, extend and modify Perrott House in Skibbereen. It was suggested that the residential component be reduced to a more manageable twenty residents and a day hospital and day centre be provided to serve the Skibbereen sector and the residents of the house respectively.

Three community nurses served the catchment area; two worked from Bantry and one from Skibbereen. In addition, for some time an initiative had been under way in which a nurse worked with some local GPs to aid clinical practice and to improve relationships with primary care. The service had written documentation concerning its objectives, purposes and aims. There seemed to be a fairly coherent understanding of where the service should move in terms of increasing community services, including accommodating those younger long-stay patients who would be the subject of attention when the new rehabilitation programmes were put in place in Cork. However, a plan on how to deal with the admission and transfer of West Cork patients to Our Lady's Hospital, Cork was required as were measures to deal with more disturbed patients in the local service without moving them to Cork City.

The in-patient setting in Bantry was comfortable and reasonably well decorated and patients had access to the hospital grounds. The bathing and toilet facilities were reasonably adequate and private. There was an adequate occupational and recreational department on the ground floor which was appropriately staffed. Patients had access to smoking and non-smoking areas, a telephone, information about the service and other relevant ancillary services.

There was reasonable continuity of nurse staffing and a key worker or primary nursing system was in operation. Nursing care plans were used and the model in place had been adapted for local purposes. The care plans were kept reasonably up-to-date. A nursing procedure book available to staff was also up-to-date and an induction procedure for nursing staff was in place.

The medical case note records were less satisfactory. There were no written instructions as to how the case notes should be organised, how entries should be made and how records, medical investigations, and reports by social work and occupational therapy staff should be filed. Neither the admission nor final diagnosis was recorded in accordance with ICD classification. Generally speaking, case notes were not signed in full, nor was it possible to identify the signatory. The written inputs were poorly organised and lacked detailed information on such issues as the history of the presenting complaint, personal or family history or mental state examination. In one case examined, there was no written indication that a physical examination had been carried out when they were admitted. Neither was there any documentation that a clear care plan in relation to the patient's management was put in place. Overall, medical case note documentation was poor. In some instances, discharge letters had not been written to local GPs. Similar difficulties arose in relation to prescription cards; although there was a written drugs policy and procedure, legibility of prescription entries was poor and nursing staff admitted to having some difficulty in

deciphering them. Neither were all prescriptions signed and dated individually. Prescribed medication was not recorded in case notes.

Information for patients was available on admission and documentation about the service was presented to patients on admission. There was a written procedure for dealing with complaints from patients and their relatives — a book recording such complaints was kept for inspection by the complaint officers. Drugs were supplied from the nearby pharmacy in safe containers but the pharmacist did not visit the unit. An emergency tray was in place and was checked regularly. Fire committee meetings were held regularly and records were kept. Fire exits were clearly marked, there were written fire orders, and evacuation drills were performed in all service locations. Automatic fire-detection systems were also in place.

The quality of food and the choice available had improved considerably; however, there was still no written menu. Adequate facilities for educating and training staff were provided and several staff attended courses in University College Cork. New library facilities had been installed in the unit in Bantry. They were much appreciated by staff and were frequently used. There was a written safety statement for the hospital and a safety committee with an identified safety officer was in place. Safety statements were available in each local area and incidents of violence were recorded. All staff were trained in the management of violence and aggression.

RECOMMENDATIONS

It is recommended that:—

1. Improved headquarters and day hospital accommodation be provided in Skibbereen, with a much more prominent medical presence operating from the sector.
2. The day hospital project for Dromleigh to serve the Bantry area be expedited.
3. The rehabilitation of West Cork patients from the Cork city services be a priority for the new rehabilitation team to be established in Cork, with appropriate residential accommodation in the West Cork catchment area for this purpose.
4. Admissions from the West Cork catchment area should be in the first instance to the Bantry unit.
5. In the context of recommendation no. 4 above, the putting in place of a safe room, or some other suitable facility, to deal with the more ‘difficult’ admissions from the catchment area which currently are sent directly to Our Lady’s Hospital in Cork city.
6. Smoking be discouraged in the sleeping areas of Perrott House, Skibbereen.

CHAPTER NINE

Western Health Board

EAST GALWAY MENTAL HEALTH SERVICE — 2001 INSPECTION

INSPECTED ON 12 JULY AND 6 SEPTEMBER, 2001

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 91,619 was divided into four sectors as follows:—

Sector	Population
Ballinalsoe/Mountbellew	24,149
Portumna	20,762
Loughrea	21,627
Tuam	25,081

IN-PATIENT CARE

In-patient care was provided at St Brigid's Hospital, Ballinasloe where 280 beds were provided in six male, three female and six integrated wards.

Age and Length of Stay of all Patients at 31.12.00

Age **Length of Stay**	**<15**	**15-19**	**20-44**	**45-64**	**65-74**	**>75**	**All Ages**	**% of Total**
< 3 Months	—	—	18	6	6	4	34	12.14
3-12 Months	—	—	1	9	1	3	14	5.00
1-5 Years	—	—	7	12	9	9	37	13.22
> 5 Years	—	—	13	55	76	51	195	69.64
All Lengths of Stay	—	—	39	82	92	67	280	100
% of Total	—	—	13.93	29.28	32.86	23.93	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	**Schizophrenia**	**Other Psychosis**	**Depressive Disorders**	**Mania**	**Neurosis**
19	134	2	18	17	13
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
5	13	—	58	1	280

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	161	91	252
Temporary	10	5	15
P.U.M.	9	4	13
Ward of Court	—	—	—
Total	180	100	280

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 708
Number of first admissions in 2000 221
Number of discharges in 2000 708
Number of deaths in 2000 45

Legal status of admissions
Voluntary 80.5%
Non-voluntary 19.5%

The number of admissions represented an admission rate of 7.7 per 1,000 of the catchment population. First admissions accounted for thirty-one per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	4	65	450
Day Centres	5	140	180
Out-patient clinics	5	248*	743

*No. of out-patient clinics held in 2000

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
27	103	7	47	8	97

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
13	28.5	331	197.1	8

COST

The cost of the East Galway Mental Health Service was £21 (€26.7) million in 2000.

GENERAL COMMENTS

There had been some community initiatives in the East Galway service since the previous inspection. Premises for community residences had been purchased at Portumna and Tuam and a second house in Portumna was likely to be purchased shortly after the inspection. This accommodation would be used to house patients from the Toghermore facility

which was in need of considerable expenditure to make it structurally sound; the Board's policy was to move residents from Toghermore to alternative community placement and, ultimately, to close it. This was unfortunate as the additional accommodation would not then be available to accommodate patients from St Brigid's Hospital. Planning permission had been sought for a supervised residence of eight to ten places in the convent premises at Headford. In the same building, renovation was being carried out to provide day centre accommodation. In Gort, the Vocational Education Committee was making premises available to the Board for a day hospital and sector headquarters. Two houses had been leased, one in Ballinasloe and one in Killimer, for the relocation of learning disability patients from St Brigid's Hospital. A new day hospital and sector headquarters were to be provided in a health centre in Ballinasloe.

Five adult psychiatrists, including the newly-created specialist rehabilitation post, were now employed in the East Galway service and a realignment of the existing sectors would be necessary in the light of this development. The fifth adult psychiatry post had come about because Comhairle na nOspideal, instead of approving the consultant psychiatrist for later life post requested by the Board, provided a general adult psychiatry post for reasons unclear to the Board. The Board felt that a later life psychiatry service for East Galway and Roscommon would have been more appropriate. Two of the consultant posts were filled in a temporary capacity. One social worker and three psychologists were employed by the service but there were no occupational therapists.

There were approximately 250 patients in St Brigid's Hospital on the day of inspection. They were roughly divided into four groups: older persons who constituted almost sixty per cent of the in-patient population; learning disability patients who accounted for fourteen per cent of patients; acute short-stay admissions accounting for nine per cent of patients; and the remainder who were younger long-stay patients. Specialised approaches needed to be adopted to deal with these groups of patients. Accommodation for the older patients, whose disabilities almost exclusively related to the physical conditions of age, should be de-designated and dealt with by a comprehensive service for older persons. Community-based places in nursing homes or other equivalent locations would be the ideal solution. In the meantime, their care in St Brigid's should be managed by a GP service with psychiatric consultation as required.

The learning disability patients needed specialised accommodation in the community and houses had been leased in Ballinasloe and Killimer to relocate fifteen of these patients from St Brigid's. The service was recruiting appropriate nursing staff for these community residences. Once this happened, one of the intellectual disability wards in St Brigid's would close. It had been planned to apply to RESPOND, a voluntary housing agency, to provide accommodation for some of the remaining learning disability patients on a site on St Brigid's campus donated by the Board. Unfortunately, planning permission for this had been refused. With the appointment of a consultant in rehabilitation psychiatry, the rehabilitation of the younger, long-stay patients should progress. It was important that a multi-disciplinary support team be put in place for this service and that additional community residential accommodation be acquired to enable these patients to move out of St Brigid's.

The matter of dealing with acute admissions hinged on the provision of an acute psychiatric unit in Portiuncula Hospital. Little progress had been made on this issue, despite earlier joint meetings between the Department of Health and Children, the Western Health Board and the hospital. However, it was reported that the Western Health Board was taking possession of Portiuncula Hospital shortly after the inspection and that a control development plan for the entire hospital, including the acute psychiatric unit, would be put in place shortly afterwards. In the meantime, the admission facilities in St Brigid's were being upgraded.

The entire admission procedure in St Brigid's was unsatisfactory. As noted in previous reports, many patients from West Galway were transported directly to St Brigid's on PUM forms by Gardaí, bypassing the psychiatric unit in UCH, Galway. Some, without being admitted, were diverted from the psychiatric unit in UCH Galway, while others, having been admitted to the unit in Galway and deemed unsuitable, were then transported to St Brigid's. This was further compounded by the large number of patients who arrived at the admission unit for assessment, either having been referred by their GP or arriving independently. As a consequence, St Luke's admission unit was frequently overcrowded. Clearly, an admission unit should not serve an assessment function; this should be carried out in mental health centres or day hospitals in the sectors. On the day of inspection, although there were twelve designated beds, the number of patients exceeded this and beds had been put up in consulting rooms and in the observation areas. This was unsatisfactory and it was hoped that the application of new legislation would get over the problem of the Gardaí placing people on PUM forms and referring them exclusively to Ballinasloe, which they regard as legally the only district hospital in Co Galway for the reception of persons of unsound mind.

The policy of having two admission wards with separate but overlapping functions was confusing; it was felt that one admission ward should be sufficient for the catchment area. It was noted that, while extra beds had been put up in St Luke's admission unit, the St Dympna's twenty-two-bed admission unit had only nine patients. The confused admissions policy had other consequences too. For example, a man had been brought six days previously by Gardaí on a PUM form directly to Ward 1 in St Brigid's, where, on admission, he had been reviewed by the admitting doctor and by a consultant. He had improved considerably since his admission and it was doubtful whether he needed to be further detained in the locked, intimidating environment of Ward 1. However, there had been no medical review of his condition since his admission. This was unsatisfactory.

It was evident that, although the geographic delineation of sectors in the East Galway service was proceeding, the establishment of appropriate community facilities, including community residences, sector headquarters, mental health centres and day hospitals, was very important. The multi-disciplinary nature of the teams needed to be strengthened and more nursing staff deployed to the community. In this context, it was made quite clear that there were considerable constraints on progress with regard to nurse deployment in this and other areas of service delivery. The quite unsatisfactory recommendations of the recent Commission on Nursing were seriously hampering progress. Because financial rewards were greater for persons working in in-patient settings, staff were understandably

reluctant to move to community settings. Similarly, because duty in certain in-patient locations, such as locked wards, was more financially rewarding than in less restraining settings, staff were moved around continually so that all could share in the benefits accruing from working in locked wards. Consequently, continuity of care and the appointment of a key worker system became impossible.

Progress was slow in the East Galway service and there appeared to be an absence of co-ordinated planning, identification of objectives, setting-up programmes, devising strategies and tactics to achieve aims and objectives, and little by way of continuous monitoring, review and audit. All of this led to uncertainty, confusion and the perception of a lack of transparency and openness as to where the service was going.

There were fifteen episodes of seclusion involving six patients and 276 spans of special one-to-one nursing supervision involving sixty-three patients in 2000. Thirty accidents to patients and twenty-nine accidents to staff and thirty-five assaults on patients and twenty-five on staff were recorded in the same year. Ten accidents and fourteen assaults required further medical intervention. Twenty-three patients discharged themselves from hospital against medical advice and 144 patients lodged overnight in the service but were not formally admitted. Appropriate follow-up arrangements were in place for those patients who discharged themselves against medical advice. Sixty-two patients were prescribed ECT at St Bridget's Hospital in 2000.

RECOMMENDATIONS

It is recommended that:—

1. Discussions on the provision of an acute psychiatric unit at Portiuncula Hospital, Ballinasloe should proceed.
2. A comprehensive programme for the care of older persons be put in place in East Galway to cater for the older patients in the new building and for older patients coming into the service. All of these in-patient care areas should be de-designated.
3. A management team to establish and implement policy on the future of St Bridget's Hospital be put in place. It would need to consider the respective needs of the long-term functional psychotic patients, patients with an intellectual disability, acute patients and older patients residing in the hospital.
4. A multidisciplinary rehabilitation team be established and appropriate rehabilitation inputs developed for all patients requiring this level of care.
5. The service consider utilising one admission unit for the catchment area instead of the two currently in existence.
6. Medical notes in the long-stay wards be kept up-to-date with the minimum standards as set out in the Mental Treatment Act, 1945 and amending legislation in relation to medical and psychiatric assessments be adhered to.
7. A new day hospital and sector headquarters be provided in the Ballinasloe area.
8. All sectors within the catchment area be realigned to cater for the additional consultant post.

9. The planned community developments in Gort, Headford, Killimer and Ballinasloe be expedited.
10. The provision of modern furnishings, appropriate bed screens and the upgrading of the wards in St Bridget's Hospital to continue.
11. Additional occupational therapy staff be employed.

WEST GALWAY MENTAL HEALTH SERVICE — 2001 INSPECTION

INSPECTED ON 4 SEPTEMBER, 2001

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 100,000 was divided into four sectors as follows:—

Sector	Population
Oughterard	9,500 (+15,000)*
Clifden	8,600 (+15,000)*
Carraroe	10,500 (+15,000)*
Oranmore	8,900 (+15,000)*

*Represents a quarter of Galway City population

IN-PATIENT CARE

In-patient care was provided at the seventy-three bed acute psychiatric unit, University College Hospital (UCH), Galway. It was divided into one male, one female and one integrated unit.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	27	13	1	—	41	97.62
3-12 Months	—	—	—	—	—	—	—	—
1-5 Years	—	—	1	—	—	—	1	2.38
> 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	—	28	13	1	—	42	100
% of Total	—	—	66.67	30.95	2.38	—	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
2	13	2	9	3	5
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
3	2	1	2	—	42

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	33	25	58
Temporary	8	3	11
P.U.M.	—	—	—
Ward of Court	1	—	1
Total	42	28	70

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 745
Number of first admissions in 2000 41
Number of discharges in 2000 757
Number of deaths in 2000 3

Legal status of admissions
Voluntary 90.2%
Non-voluntary 9.8%

The number of admissions represented an admission rate of 7.45 per 1,000 of the catchment population. First admissions accounted for 5.5 per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	20	180
Day Centres	4	129	122
Out-patient clinics	9	477*	Not available

*No. of out-patient clinics held in 2000

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
6	28	4	21	1	9

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
12	13	104	26	15

COST

The cost of the West Galway Mental Health Service was £5.7 (€7.2) million in 2000.

GENERAL COMMENTS

There had been some new initiatives and further plans for the expansion of the West Galway service in the past year. Bredagh House, a seven-bed medium-support residence in Galway city, had opened and Acorn House nearby had been purchased and was to be

renovated as a day centre. It would replace the unsatisfactory day centre facility at Halla Padraic. One new high-support residence was envisaged for Clifden in conjunction with a local voluntary housing initiative. An upgraded day centre premises was also projected for Clifden to provide an adequate resource for those in the new residence as well as for the local community. In UCH, Galway there were plans to provide a substantial new out-patient block which it was hoped would serve the mental health service as well as other hospital departments. This would be an important development as out-patient clinics were still held in the psychiatric unit which was unsatisfactory.

The population spread of the catchment area was unbalanced. Galway City provided the only major concentration of people on the periphery of a large sparsely populated geographical area. This created difficulty in providing comprehensive sector headquarters, day hospitals and mental health centres in the Carraroe and Clifden sectors. A day hospital/day centre had opened some years ago appended to the in-patient unit, but Galway City had no true sector headquarters or community mental health centre. This was an urgent need and attempts should be made to identify a suitable premises in downtown Galway. The psychiatric unit at UCH, Galway needed to be refurbished and redecorated as has been highlighted before. The unit had forty-two beds but there were plans to upgrade it and increase the number of beds to fifty by the addition of an acute observation area. This was necessary to try to eliminate the direct admission of patients from the West Galway catchment area to St Brigid's Hospital in Ballinasloe. Likewise, it would end the transfer of patients deemed unmanageable from the unit to St Brigid's. It would also end the undesirable practice of 'lodging out' patients from the unit to Unit 9B, Merlin Park Hospital when beds were not available for patients requiring admission. On a related matter, the Board was considering a site for the provision of an intensive care unit for the Western Health Board area.

The day hospital, although spatially suited to its purpose, did not maximise its potential. The Inspectorate felt that no clear view of its purpose and function had been formed and its clinical administration appeared to be blurred and undirected. As a result, it operated more as a day centre rather than a day hospital catering for more seriously ill patients.

It was disappointing that Unit 9A, Merlin Park Hospital functioned as a high-support residence with the additional and unnecessary task of providing two beds for lodgers from the acute unit. It was originally funded as an active rehabilitation unit for West Galway patients in St Brigid's Hospital but never functioned adequately as such. The unit should cease taking lodgers and it should be de-designated as there was no reason why the residents should be detained on admission forms. It was disturbing that community residential accommodation, for which many of the patients were suited, was still lacking despite the recent initiatives. It was a matter of concern that no active programme or team existed for their rehabilitation, nor for the rehabilitation needs of the entire service. This deficit should be remedied.

An additional consultant post with responsibility for later life psychiatry had been approved and was to be filled on a temporary basis shortly after the inspection and the resources required to fund a full multidisciplinary team had been made available. This

was a welcome development. However, no sub-unit for acute assessment purposes was being made available to later life service nor could such a facility be made available within the existing unit without structural alterations. Thought should be given to remedying this defect with the imminent enlargement of the unit.

Documentary procedures in relation to in-patients were checked thoroughly. The standard of the medical case notes varied. Overall, case note histories were poorly designed and quite unstructured. The notes contained no written instructions on how to complete the case records. There was no room for ICD diagnoses and, in the majority of cases, there was no written or numerical diagnosis either on the top sheets or in the case notes themselves. Generally speaking, the notes were legible but some proved extremely difficult to decipher. For the most part, case note entries were dated and signed in full but, in a minority of cases, initials only were entered and nursing staff were unable to identify who had made the entry in many instances. Admission pathways were clearly documented in most case notes, as were the history of the presenting complaint, past history and personal family history. Case notes did not usually record current medication or dosage. Clear case summaries following admission and management plans and further care planning, including the identity of a key worker, were not entered. In general, clinical medical progress notes were adequate but, in some instances, consultant entries were sparse. In one case, nursing staff were unable to identify any consultant entry although the patient had been hospitalised for over two months. In this case, the junior doctor recorded that they had discussed the case with the relevant consultant but there was no written documentation by the consultant and, therefore, no evidence that the consultant had ever seen the patient directly. Although it was reported by nursing staff that consultants always saw patients within twenty-four hours of admission, inspection of the case notes did not confirm this. Discharge letters seemed to be written but they did not contain final ICD diagnoses in the majority of cases.

The nursing records examined appeared to identify problems that had arisen and actions taken by staff to rectify them. Records were generally written clearly and dated accurately. The time of entry should also be recorded. All entries were signed. Efforts should be made to ensure that patients acknowledge the problems identified and show a willingness to assist in any actions determined. It was recognised that not all patients would be able to participate in this process. Evaluations of nursing care plans should include the patients' view of their progress and records should indicate that patients were given the chance to talk about their fears about admission to hospital.

The written drugs policy and procedure was last reviewed in 1992 and needed to be reviewed and updated. A number of prescription cards were examined. The legibility of individual prescriptions was generally satisfactory and those scripted were not difficult to read. Most of the prescriptions were in block lettering which was satisfactory. While all prescriptions were signed and dated individually and changes were written as new prescriptions, there was a need for the full signature of the person prescribing to facilitate easier identification of the practitioner in future. There was provision within the prescription cards for recording known drug allergies which ensured that information was readily available to staff. Discontinued drugs were signed off using the discontinuation column.

Generally speaking the standard of prescription writing and drug recording in the acute unit at UCH, Galway was satisfactory.

Twenty-seven patients were prescribed ECT at UCH, Galway during 2000. The facilities for ECT comprised waiting, treatment, and recovery areas and were of a high standard. The treatment room was well equipped and the recovery area provided adequate privacy for patients. The consent form for ECT treatment was satisfactory. The preparation check list should be reviewed and updated to include a pre- and post-treatment nursing check list. There were 450 spans of special one-to-one nursing supervision involving twenty-nine patients during 2000. The policy and procedure relating to special nursing supervision was available in each clinical area for staff information and reference.

Nine patients had their temporary reception orders extended during 2000. Documentation checked relating to temporary admission orders was satisfactory. Seven complaints/appeals were made by patients or relatives to the local complaints/appeals manager in the same year and all appeared to have been dealt with satisfactorily. Twenty-six accidents to patients and one accident to a staff member were recorded in the acute unit during 2000. None were deemed serious. Four assaults on patients by other patients and four assaults on staff were recorded and one of the assaults on a staff member required further medical intervention. A safety statement was available in the clinical area but it was not dated. The safety statement should be revised and dated and a system of periodic safety audits introduced with records of hazard control sheets available in each local area identifying high, moderate and low risks, the action required and who was required to rectify them.

A policy and procedure manual was readily accessible in the clinical areas for staff information and reference. The following issues should be considered by the policy review committee with a view to having them included in the policy and procedure manual: access to health records; accidents and incidents; handling/lifting policy and procedure; hepatitis B vaccination; informing patients of their rights; panic alert; activation policy; management of patient's money and handling of personal property; patient's voting rights; and personal searches of patients and their belongings. The policy and procedure manual should include guidance notes for staff required to appear in court.

A number of patients at UCH, Galway were interviewed to ascertain their views on the level of service provided. Patients interviewed were generally satisfied with the admission process. All reported that they had been introduced to the medical, nursing and other staff on admission. They knew the name of their consultant psychiatrists and felt they had adequate access to them whilst hospitalised. Patients reported being informed of their medical condition and understanding the explanations given. They were aware of the primary nursing system in operation at the unit and knew their primary nurse. Patients reported general satisfaction with the cleanliness of the bathrooms and toilets but they cited a 'lack of imagination' in the presentation of food and suggested some improvement was necessary. Patients were generally satisfied with storage for clothing and personal belongings and with washing facilities for personal clothing. When asked how they found the ward environment, patients responded that it was safe and reassuring and, when asked

to describe the ward decor, they responded that it was basic and 'could do with redecoration and modern furnishings'. Patients were particularly critical of the facilities in the day area. (These were being upgraded at the time of inspection where a new designated smoking room was being provided.) Patients reported easy access to telephones and to fresh air. All were generally satisfied with the care provided at the acute unit.

Patients reported being given information about prescribed medication, its long- and short-term effects and prohibitions. One patient was not satisfied with the information provided, finding it vague. Most patients reported that they would like written information about medication, in addition to verbal explanations. Patients were generally satisfied with the occupational therapy activities on offer, though one commented on the unsuitability of a gardening project in an acute unit. One patient expressed a fear of divulging information due to complex and difficult circumstances as they were unaware who had access to information divulged to the treating doctor.

RECOMMENDATIONS

It is recommended that:—

1. Premises be identified in Galway City to serve as a sector headquarters/community mental health centre.
2. The day hospital adjoining the acute unit at UCH, Galway be the subject of serious scrutiny and consideration, in relation to its objectives, function, organisation and management, to enable it to extend the range of patients to whom it provides services.
3. The acute unit be upgraded internally and externally.
4. The proposed community developments in Clifden and Ballinahabhann (Carraroe) be progressed as soon as possible.
5. A multidisciplinary team be provided on a full-time or part-time basis, as deemed appropriate, to specialise in the rehabilitation of patients with enduring psychiatric disorders of a seriously disabling nature in the West Galway service.
6. Unit 9, Merlin Park Hospital, be de-designated from an in-patient unit to a high-support residence.

MAYO MENTAL HEALTH SERVICE — 2001 INSPECTION

INSPECTED ON 5 SEPTEMBER, 2001

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 11,000 was divided into five sectors as follows:—

Sector	Population
Castlebar	13,000
Ballina	25,000
Westport	25,000
Swinford/Claremorris/Kiltimagh	26,000
Achill/Belmullet	22,000

IN-PATIENT CARE

In-patient care was provided at St Mary's Hospital, Castlebar where 170 beds were provided in four male, three female and two integrated units.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	2	8	15	7	5	37	21.77
3-12 Months	—	—	11	10	7	—	28	16.47
1-5 Years	—	—	6	12	7	8	33	19.41
> 5 Years	—	—	—	26	17	29	72	42.35
All Lengths of Stay	—	2	25	63	38	42	170	100
% of Total	—	1.18	14.71	37.06	22.35	24.70	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
3	98	—	27	16	1
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
1	7	1	15	1	170

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	97	64	161
Temporary	7	2	9
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	104	66	170

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 628
Number of first admissions in 2000 107
Number of discharges in 2000 630
Number of deaths in 2000 6

Legal status of admissions
Voluntary 88.1%
Non-voluntary 11.9%

The number of admissions represented an admission rate of 5.66 per 1,000 of the catchment population. First admissions accounted for seventeen per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	2	40	128
Day Centres	8	108	301
Out-patient clinics	10	223*	851

*No. of out-patient clinics held in 2000

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
7	29	5	41	5	39

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
11	21.5	238.5	110.1	6

COST

The cost of the Mayo Mental Health Service was £13.1 (€16.6) million in 2000.

GENERAL COMMENTS

The 2001 inspection of the Mayo Mental Health Service was a revelation. Clearly defined plans and objectives as to where the service was going within the next couple of years were available and a huge amount of work had been accomplished in the past year.

Clearly defined targets had been set for developing the sectors and many of these had already been achieved or partly-achieved. A day facility and part sector base had been established in Belmullet for the Achill/Belmullet sector. A site behind the existing community residence and day centre in Ballina had been selected for the construction of a comprehensive sector headquarters and enlarged day hospital and work was to begin shortly after the inspection. Two new houses had been purchased and a third purchase was imminent. These would provide replacement and additional community residences. A new workshop, Ard na Rí, had opened in an industrial complex in Ballina and augmented the existing training facility in the town. This facility was impressive in its own right and had a substantial training value in many areas, including a dry cleaning service for the public. The combined training input had been very successful in occupying and rehabilitating patients with severe illness and disability.

The new day hospital/day centre which opened in Westport last year was functioning satisfactorily and a site had been identified for a new sector headquarters in Claremorris for the Swinford/Claremorris/Kiltimagh sector. In Kiltimagh itself, a former community

residence, the O'Hara Home had been converted and refurbished to a high standard to serve as a day centre/day hospital and a house which was formerly in poor repair had been fully refurbished.

It was considered important that rehabilitation be acknowledged as a sub-speciality within the service and that an appropriate rehabilitation team be set up either on a full- or part-time basis as deemed appropriate. Once this took place, St Teresa's Unit would close for major refurbishment to assume its new role as an active fifty-bed rehabilitation unit/residence. Two days before the inspection, twenty-one long-stay patients transferred from St Mary's to three high-class bungalow residences in Swinford which were originally part of the Aras Attracta complex. As a result, two wards in St Mary's closed the same day. As a consequence, there were only 102 patients in St Mary's on the day of inspection. It was planned that fifty of these would transfer to the refurbished St Teresa's Unit for rehabilitation purposes, another fifteen would move from the existing intensive care unit to a new high-support residence and the remaining thirty-five patients, a majority of whom were older patients, would be placed in private nursing home accommodation, the Sacred Heart Home, or in community residential accommodation. This process was expected to take less than two years, by which time St Mary's would close as a psychiatric facility.

The training workshop situated on the St Mary's Hospital complex, which had made a very valuable contribution to the rehabilitation of patients in Castlebar, was now closed and had been replaced by an impressive new workshop. Some of the long-stay accommodation in St Mary's was criticised strongly in the 2000 report. Since that inspection, three of the existing five wards had been substantially refurbished and upgraded to a very high standard, within the limitations of their structure, and this had greatly improved living conditions for the patients remaining in St Mary's. Unfortunately, the same could not be said of the intensive care unit which continued to cause considerable concern. However, this ward was due to close on the completion of a new high-support residence scheduled to open in February, 2002.

A new service of later life psychiatry had been put in place and a permanent consultant, with supporting staff, was to be appointed shortly after the inspection. The appropriate acute assessment and continuing care beds for this service would be provided between the new general hospital unit and the Sacred Heart Home. Attempts were being made to enlarge the number of social workers, psychologists and occupational therapists in the service to provide true multidisciplinary teams in all five sectors.

There were 1,246 spans of special nursing supervision involving twenty-two patients in 2000 and seclusion was not used in the service. Seventeen patients in St Theresa's Unit were prescribed ECT in the same year. Sixty-seven patients lodged overnight in the service but were not formally admitted. Eight patients discharged themselves from the hospital against medical advice and appropriate arrangements were in place to follow up patients. Nine complaints/appeals were made by patients or their relatives to the local complaints/appeals manager and all appeared to have been dealt with satisfactorily. Thirty-six accidents to patients and thirteen accidents to staff were recorded in St Mary's Hospital during 2000 and five required further medical intervention. Of nineteen assaults

on patients by other patients and forty-four assaults on staff, one of the patient assaults and two of the staff assaults required further medical intervention.

There was a written drugs policy and procedure for the community services dated February, 2000 but a policy and procedure for the hospital services was not available. A number of prescription cards and drug administration cards were examined. Individual prescriptions were legible and the majority were individually signed and dated. Changes in prescriptions were written as new prescriptions and space was provided to record information relating to drug allergies. This ensured the easy availability of information to staff. Generally, discontinued drugs were signed off using the discontinuation column. On a small number of prescriptions examined, the number of discontinued prescriptions exceeded the number of current prescriptions. These should be rewritten as they posed an increased risk of error of administration.

The community residences inspected in Castlebar, Ballina, Swinford and Kiltimagh provided good quality, comfortable and well-designed accommodation which met the needs of residents. They were satisfactorily decorated, well-maintained and adequate security and automatic fire detection systems to protect the property and the residents were provided. All residences had telephones and the residents knew who to contact in an emergency. The on-going improvements to community facilities were welcomed, especially the upgrading of the Avondale and O'Hara Residences in Kiltimagh. Fire safety procedures at the residences in Kiltimagh needed to be reviewed.

The quality of the nursing records varied. Although basic nursing notes were recorded in the intensive care unit and in some of the long-stay wards, entries were frequent in all locations. A nurse care planning system using the 'Roper Model' of nursing was in place in St Theresa's Admission Unit. It was suggested that the nursing records be audited to assess standards in order to identify areas for improvement. Records should reflect the involvement of patients in planning and making decisions about their own care and treatment. Patients' views about their progress and any negotiated change in care plans should be recorded in the nursing records. The records examined were written clearly but some signatures, particularly in the intensive care area, were illegible. All entries were dated but the time of entry and the full signature of the staff member making an entry should also be recorded. The signature of the nurse completing the nursing assessment form in St Theresa's admission unit should also be recorded. Some system of sequencing continuation pages was required. There was a considerable collection of loose continuation sheets in a number of records and they did not seem to be filed in any sequence. As abbreviations were noted in the records examined, a written policy on the use of abbreviations was required.

A written safety statement which adhered to the standards set by the Safety and Welfare at Work Act, 1989 was available. The safety statement in the intensive care unit at St Mary's Hospital dated from 1993 and required review. Copies of hazard control sheets indicating periodic safety audits at this location were not available.

A number of patients in St Theresa's Admission Unit were interviewed to ascertain their views on the level of service provided. They were generally satisfied with the admission

process and with the courtesy and helpfulness of staff. All knew the name of their consultant psychiatrist and felt they had adequate access to them whilst hospitalised. They all felt they were informed about the nature of their medical condition, including medication and treatment, and understood what was explained to them. The patients interviewed reported not being informed about their rights under the Mental Treatment Act, 1945 or on how to make a complaint if they felt aggrieved and they were not satisfied with the cleanliness of toilets and bathrooms. Problems included a malfunctioning flushing mechanism in the male toilet, no locks on the toilet doors, no bulbs in the toilet cubicles, a female toilet that was out of order, lights in the toilet areas that were not working and a toilet which had no seat. Patients reported adequate storage space for personal clothing and belongings and facilities to wash personal clothing were available.

All of the patients interviewed felt the ward environment could be improved by redecorating it but they described the unit itself as therapeutic. They enjoyed access to the fresh air, views of landscaped gardens, trees and shrubs and the space surrounding the unit. All patients interviewed reported a general satisfaction with the activities programme offered by the nursing and occupational therapy staff. The activity programme, known as TAP, was established in November, 1999 using a multidisciplinary approach and it aimed at providing a range of high-quality therapeutic interventions for patients. Patients reported that they found the range of activities helpful. Patients reported easy access to a telephone and hot and cold drinks. Those interviewed were unaware as to whether or not there was a nurse with primary responsibility for their care. However, they felt they had adequate contact with nursing staff during the day but not enough contact at night as night staff tended to remain in one location. All patients reported an active involvement in decisions affecting their care and treatment and all felt they were receiving adequate care in St Theresa's Unit.

RECOMMENDATIONS

In view of the considerable progress already made and that envisaged in the future for this service, it is the view of the Inspectorate that it would be inappropriate to make any recommendations relating to the Mayo Mental Health Service in this year's report.

ROSCOMMON MENTAL HEALTH SERVICE — 2001 INSPECTION

INSPECTED ON 15 AUGUST, 2001

GENERAL DESCRIPTION OF THE SERVICE

The catchment area population of 52,726 was divided into three sectors as follows:—

Sector	Population
Boyle (North)	18,865
Castlerea (Mid)	17,094
Roscommon (South)	16,767

IN-PATIENT CARE

In-patient care was provided at the thirty-bed acute psychiatric unit, Roscommon General Hospital.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	2	3	2	4	1	12	92.31
3-12 Months	—	—	1	—	—	—	1	7.69
1-5 Years	—	—	—	—	—	—	—	—
> 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	2	4	2	4	1	13	100
% of Total	—	15.38	30.77	15.38	30.77	7.69	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
—	3	—	4	2	1
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
—	2	1	—	—	13

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	6	4	10
Temporary	1	—	1
P.U.M.	—	1	1
Ward of Court	—	—	—
Lodger	—	1	1
Total	7	5	13

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 446
Number of first admissions in 2000 120
Number of discharges in 2000 449
Number of deaths in 2000.....1

Legal status of admissions
Voluntary.....91.7%
Non-voluntary 8.3%

The number of admissions represented an admission rate of 8.4 per 1,000 of the catchment population. First admissions accounted for twenty-seven per cent of all admissions.

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	1	10	459
Day Centres	6	161	286
Out-patient clinics	8	242*	723

*No. of out-patient clinics held in 2000

Community Residences

Low Support		Medium Support		High Support	
No. of residences	No. of places	No. of residences	No. of places	No. of residences	No. of places
2	13	4	39	1	16

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
9	9.6	139	62	6

COST

The cost of the Roscommon Mental Health Service was £7.6 (€9.7) million in 2000.

GENERAL COMMENTS

The Roscommon Mental Health Service had plans to provide a much-needed day hospital/sector headquarters/mental health centre in Roscommon town. The need for such a facility was urgent and had been highlighted in previous Reports. Short-term plans involved renting suitable premises already occupied by the health board on Lanesboro Street. It was hoped to purpose-build an appropriate structure on a green-field site owned by the health board four to five years later. The current day premises comprised two small rooms and was unsuited for its purpose, both in its size and in its location. In addition, the mix of day patients and in-patients was unsatisfactory. A bungalow in Athlone had been identified for use as a new day hospital/day centre and money was available for its purchase to replace the existing unsatisfactory premises in Connaught Street. As there was no high-support residence in Roscommon town, the service was most anxious to purchase/lease a premises for this purpose.

The 2000 Inspector's Report recommended the establishment of a specialist rehabilitation service for the county, if necessary on a part-time basis given the limited catchment area population or a full-time service shared with that already operating in East Galway. A similar initiative relating to specialist psychiatric services for older persons should also be explored with the neighbouring East Galway service. The Roscommon service itself would be proposing full-time services for the county in both specialities in its five-year service plan.

Of the three Roscommon sectors, it appeared that only the Boyle sector was operating as a true mental health centre or sector headquarters with assessment of patients carried out within the sector rather than in the acute psychiatric unit at Roscommon General Hospital. This probably accounted for the sector's relatively low admission rate. In the absence of community-based assessment facilities in the other sectors, many patients were referred, or came directly, to the psychiatric unit for assessment where many lodged overnight before being assessed the following day. This was unsatisfactory and highlighted the urgent requirement for appropriate community-based premises in Roscommon and Athlone. The Castlerea premises, Naomh Chaolain, with its multiple functions, was seen as the sector headquarters for the Castlerea sector but it did not really function as a full-time, fully operational day hospital because of its limited medical presence.

The aspiration to provide a separate self-contained four-bed high-observation area adjacent to the psychiatric unit had not been fulfilled. The Inspectorate felt that this was not an appropriate way to deal with patients exhibiting disturbed behaviour. There had been a commitment by the Department of Health and Children to provide an intensive care unit for such purposes in the Western Health Board region and it was felt that this was a better solution to the perceived problem. In addition, the single room used for this purpose was not safe and needed major remodelling to make it genuinely safe. It was reported that this was to take place shortly after the inspection. The ECT suite had been structurally remodelled since the previous inspection and was much improved. The cramped conditions in the day hospital in the psychiatric unit had been referred to in previous reports and the sooner this facility was removed from this location the better. All staff agreed with this view. Repainting and redecoration, together with some new furnishings, had improved the appearance of the unit. Three-and-a-half occupational therapists were employed in the service but there were no social workers or psychologists. This needed to be remedied urgently, although recruitment difficulties were acknowledged.

There were sixty-six episodes of special one-to-one nursing supervision involving four patients in the service in 2000. A new observation policy and procedure was being considered at the time of inspection. The new system included four levels of nursing observation. The higher level involved special nursing supervision prescribed by medical staff in consultation with nursing staff and required a named nurse assigned to supervise the patient for specific periods of duty. The second level of observation, termed the 'Red Code', was a form of observation where the whereabouts of the patient was documented at prescribed intervals. The 'Orange Code' required patients to remain in the night area and to visit other areas only when accompanied by staff. The 'Green Code' required patients to remain in the unit area. The operation of these revised policies and procedures should be monitored and evaluated once commenced. Seclusion was not used in the service.

Nineteen patients were administered ECT during 2000. Documentary procedures relating to the administration of ECT appeared satisfactory. The treatment facilities for ECT, incorporating waiting, treatment and recovery rooms, were in the process of being upgraded at the time of inspection. This entailed an enlarged treatment area where adequate monitoring and resuscitation equipment would be provided. The acute unit

admitted 121 lodgers during the year who were not formally admitted to the service. All were patients in contact with the Community Mental Health Service. Appropriate follow-up procedures were in place following their assessment at the acute psychiatric unit. Seventeen patients discharged themselves from hospital against medical advice in 2000. Two accidents to patients and two accidents to staff were recorded in 2000 and two required further medical intervention. One assault on a patient by another patient and eight assaults on staff were recorded. The assault on the patient and two of the assaults on staff required further medical intervention.

As part of an evaluation of services at Roscommon Psychiatric Unit, there were plans to survey a number of selected patients by means of a questionnaire to highlight areas pertinent to a patient's stay in hospital. This was a welcome initiative and the results of this survey will be of much interest. Documentation relating to administrative guidelines, policies and procedures was available in the clinical area for staff information and reference. These guidelines provided a framework for a consistent approach to staff decision-making. Each policy, procedure and guideline should have a true multidisciplinary focus and should be signed and dated with an appropriate review date. The safe work practice sheets should be removed from the policy and procedure manual and placed in the safety statement. Information relating to the Maternity Protection Act, 1994 explanatory booklet, the policy on staff absenteeism and the procedure for ordering stationery and stores were not direct patient care issues and should be removed from the policy and procedure manual and stored elsewhere in the ward office documentation. As the policies were under review at the time of inspection, it was suggested that the following matters be included in the manual:- information on making a will, misuse of illicit substances and alcohol, a press protocol re media enquiries, patients' voting rights, personal searches of patients and their belongings, locking external ward doors, a search procedure for missing patients and sudden deaths. The policy and procedure for the transfer of patients under Section 208 of the Mental Treatment Act, 1945 to the Central Mental Hospital needed to be updated.

There were fifty-five patients in boarding-out or fostering arrangements. The policy on boarding out should be referred to as 'family placement' or 'foster care' as there were no patients in the Roscommon service who boarded out under the terms of the Mental Treatment Act, 1945. In July, 2000, the service conducted a review of its Family Placement Scheme. This service was developed in the 1980s when patients had to be discharged from St Patrick's Hospital, Castlerea. Fifty-six persons were in family placements at the time of inspection. All facilities provided bed and breakfast and evening meal for patients from Monday to Friday, with full board provided at weekends. Eight schemes were approved between 1986 and 1989 and two schemes were approved in the 1990s. The focus of the scheme was on people with a disability joining an existing household and becoming part of the family social network. Placements within Roscommon varied from one person per household to a maximum of eight. While these schemes facilitated the early closure of St Patrick's Hospital, the review highlighted a number of issues that needed to be addressed. Carers received inadequate information on patients' diagnoses, explanations regarding mental illness, medication management and possible side-effects. Some providers found the role a strain and requested more support from the service for respite relief. Lack of structure for recreational activity and community integration, especially at weekends, was

highlighted. Some residents expressed dissatisfaction with placements some distance from the nearest town, where the lack of public transport meant that they had to rely on the service provider to take them out. It had to be recognised that it was difficult for any family to make an indefinite commitment to the long-term care of an individual (not least one without blood ties). A recent advertisement to recruit more ''foster parents'' had proved unsuccessful. This, together with the increasing age of those in this form of care, pointed to the need for additional residential accommodation to supplement that already available.

A number of clinical files were examined. The structure and organisation of the case notes needed attention. Medical note-taking, particularly on admission, varied. Some of the notes were of a high standard, were legible and easy to follow. The pathways to admission, history of presenting complaint, past history, personal and family history were all clearly recorded. Current medication, mental state examination and physical examination were well documented as was a clear summary and immediate management plan. The standard of other notes was moderate. Attention needed to be given to signatures which, in some cases, were initialled only, in other cases were illegible, and in one or two instances were missing altogether. Detailed care planning with stated objectives and timescales also required attention. ICD diagnoses, although sometimes given in discharge letters, were not entered on the front page of the case notes. Some notes were difficult to follow and written instructions on filing documentation within the records was required. There was provision for recording a patient's name on each continuation page but this was not always done. Investigation reports and correspondence were not always filed correctly or in chronological order and there was a considerable collection of loose clinical material in the back of some files. Discharge summaries were provided within a reasonable time after discharge. The discharge letters contained information about medication on discharge, a summary of all relevant information and follow-up arrangements and were relatively easily accessed within the notes. Follow-up appointments at out-patient departments were given to patients prior to discharge if considered clinically appropriate.

An organised nurse care planning system using the 'Roper Model' of nursing was reviewed each week. A detailed history and nursing assessment and the name of the nurse carrying out the assessment were appropriately recorded in the nursing notes examined. Records examined confirmed that patients appeared to settle well into the ward at the end of their first day and they identified problems that had arisen and actions taken to rectify them. The records were written clearly and there was a policy on the use of approved abbreviations. While all entries were accurately dated, the time of entry should also be recorded. The patient's name, date of birth and hospital number should also be recorded on each continuation page. Whilst the records examined were reasonably satisfactory, it was suggested that they reflect the involvement of patients in planning and making choices and decisions about their care and treatment. Similarly, evaluations of nursing care plans should include the patient's views about their progress, in addition to staff views.

The standard of prescription documentation was satisfactory. All prescriptions were legible, some were blocked and those that were scripted were not difficult to read. All prescriptions were signed and dated individually and discontinued drugs were signed off using

the discontinuation column. There was space for nurses' signatures on the drug administration card which was satisfactory. Prescription cards with a greater number of discontinued prescriptions than current prescriptions should be rewritten to reduce the risks of drug error.

A number of patients in the acute unit were interviewed to ascertain their views on the quality of care provided. Patients were satisfied with the admission process, knew their consultant psychiatrist, had adequate access to them whilst hospitalised, were informed about the nature of their medical condition and understood what was explained to them. Patients were generally satisfied with all aspects of privacy and dignity relating to their care. They felt that the sleeping arrangements were adequate and were satisfied with the cleanliness of toilets and bathrooms. Patients reported general satisfaction with the cheerful, homely and supportive ward environment which had been decorated recently and contained modern furnishings. All patients reported an active involvement in decisions affecting their care. Whilst patients were aware of their legal status while hospitalised, none were aware of their rights under the Mental Treatment Act, 1945 or on how to make a complaint if they felt aggrieved. Patients requested more information on prescribed medication.

RECOMMENDATIONS

It is recommended that:—

1. A day hospital/sector headquarters/mental health centre be progressed in Roscommon town as soon as possible.
2. The premises identified in Athlone be acquired to provide enhanced and extended day care in that region.
3. More active and comprehensive day hospital activity be provided in the Castlerea sector.
4. Additional residential accommodation be provided in the Roscommon sector.
5. The possibility of providing specialised services for rehabilitation and for later life psychiatry be explored, either on a part-time basis in the Roscommon service or on a full-time basis in co-operation with the East Galway service.
6. Psychology and social work vacancies be filled as soon as possible to enable true multidisciplinary team working.
7. The room used for disturbed patients in the psychiatric unit, Roscommon General Hospital be upgraded to make it a genuinely safe room.

CHAPTER TEN

Registered Psychiatric Hospitals

ST PATRICK'S HOSPITAL — FIRST 2001 INSPECTION

INSPECTED ON 17 APRIL, 2001

IN-PATIENT CARE

In-patient care was provided at St Patrick's Hospital, Dublin 8 which had 281 beds in one male, two female and six integrated units.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	7	38	36	8	2	91	68.42
3-12 Months	—	1	7	7	8	3	26	19.54
1-5 Years	—	—	1	3	3	1	8	6.02
> 5 Years	—	—	1	4	3	—	8	6.02
All Lengths of Stay	—	8	47	50	22	6	133	100
% of Total	—	6.02	35.34	37.59	16.54	4.51	100	

In-patient Population Diagnosis (31.12.00)

This information was not provided.

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	52	77	129
Temporary	2	2	4
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	54	79	133

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 1,815
Number of first admissions in 2000 699
Number of discharges in 2000 1,827
Number of deaths in 2000.....5

Legal status of admissions
Voluntary.....97.6%
Non-voluntary.....2.4%

COMMUNITY FACILITIES

A total of 340 out-patients were held at St. Patrick's Hospital during 2001 and 1,106 patients attended.

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
22	29	145	111	27

GENERAL COMMENTS

St Patrick's Hospital had embarked on a major restructuring and refurbishment programme a number of years ago which entailed the demolition of some buildings, the erection of a new unit and the refurbishing and remodelling of existing ward facilities and this was now almost complete. The buildings at St Patrick's Hospital were very well maintained and created an attractive appearance and gave a positive message about the overall care programmes to patients and the general public. The furniture and bedding was in a good state of repair and toilets and sanitary facilities were clean and fresh. The standard of heating, ventilation and lighting were adequate; urgent repairs received prompt attention and a planned programme for dealing with others issues was in place. The entire hospital had been re-wired since the previous inspection. Procedures to ensure that health and safety measures were adhered to were in place and staff were aware of health and safety issues. An annual health and safety audit was carried out and a copy of the hospital's written health and safety statement was available for inspection.

A major change since the previous inspection was the opening of the new thirty-one bed Dean Swift admission ward which incorporated twelve high observation beds. The unit was partially opened in December, 2000 and became fully operational in February, 2001. The Dean Swift ward was an integrated ward and allowed for the closure of Delaney Ward. Part of Rebecca Ward had been assimilated into Sheridan Ward; six additional male beds were provided, plus additional day and dining facilities which were badly needed at this location.

St Patrick's provided a wide range of specialised treatment programmes such as those for mood disorders, eating disorders, alcohol/chemical dependence, young adults, behavioural therapy, chronic fatigue syndrome, psychotic disorders, pathological bereavement reactions, post-traumatic stress disorders and all aspects of psychiatry of later life. Overall, standards were very high and everyone associated with the service must be commended.

Seclusion was not used at St Patrick's Hospital in 2000. A seclusion room had been provided in the new Dean Swift Unit but, for safety reasons, had not been commissioned for use. Special one-to-one nursing supervision was used as an alternative and, in 2000, there were 212 episodes of special nursing supervision involving twenty-two patients. A written policy and procedure on special nursing supervision was available for staff information and reference. Two hundred and forty-nine in-patients were prescribed ECT in 2000 and fifty-three out-patients received ECT.

A local complaints procedure was in place and a framed copy of the St Patrick's/St Edmondsbury Patients' Charter was displayed in all wards and patient areas for information and reference. Complaints were made to the local administrative nursing or medical managers and were dealt with accordingly. Records on the number of complaints were not available at the time of inspection. A total of 859 accidents to patients, ninety-two accidents to staff and four accidents to visitors were recorded during 2000. One accident to a staff member required further medical intervention. There were fifty-nine assaults on patients by other patients and sixty-seven assaults on staff and one assault on a staff member required medical intervention. The overall procedures for reporting and documenting accidents, incidents and assaults was satisfactory. There was a system of tracking and trending accidents and assaults within the hospital which generated action on the part of the management to prevent a re-occurrence.

A general information handbook for hospital patients and visitors was being re-printed at the time of inspection. This handbook offered advice and information to patients and relatives on matters pertaining to their stay whilst hospitalised. A new induction process for all new staff had been introduced since the previous inspection and an induction booklet was available for all new staff.

A number of clinical files were examined and were generally of a high standard. The admission process was clearly documented, as was the history of presenting complaint, past history, personal history, family history, mental state examination, a clear summary and immediate management plan. Patients' names were recorded on each continuation page, progress notes provided a chronological account of the illness and subsequent notes explained clinical decisions. Investigation reports were correctly filed and correspondence was filed in chronological order. The file covers were in good condition and inputs from other professional team members were appropriately recorded and formed an integral part of the clinical file. All of this was satisfactory. Copies of discharge letters were easily accessed. A discharge note was sent to the GP and others responsible for follow-up on the day of discharge. This letter contained medication on discharge, a summary of all relevant information and follow-up arrangements. The date and, where relevant, the time of medical inputs were clearly recorded in some notes and this should become standard policy and procedure. All entries in the clinical notes should contain the signature and designation of the professional making the entry. A written policy was required on the use of recognised abbreviations. On one clinical note examined, there was no written evidence of a physical examination of the patient and no written note as to why the physical examination was not carried out. All other notes examined had detailed records of the physical examination carried out when a patient was admitted.

A written drugs procedure and policy was available and it was adhered to. All prescriptions checked were signed and dated individually. Discontinued drugs were signed off using the discontinuation column and there was a system of ensuring that drug allergies or drug interactions were recorded. Generally speaking, the documentary procedures relating to prescription cards and nursing records on the administration of drugs were satisfactory. Some of the prescription cards at Emmet Ward needed to be updated. Some cards had a greater number of discontinued prescriptions than current prescriptions which

could cause confusion on the part of the nurse administering the drugs. Prescribed medication should be recorded in a patient's case notes and information on medications should be provided before patients start treatment. Details of effects and side effects should be recorded in the case notes and the information should also be provided to the patient.

Computers had been installed in all of the wards and the capacity to have them all interlinked was there. When operational, this would provide clinicians with up-to-date information at any time on admissions, discharges, waiting lists etc. A further extension of this system was the possible introduction of electronic prescriptions software and this was under consideration by the service providers.

The nursing records were generally satisfactory and up to date. The 'Roper Model' of nursing care was used at St Patrick's and appropriate staff training on this form of nurse care planning was provided. At the time of inspection, the staff at the hospital were working on a new nursing assessment system using a more eclectic model. This was an opportune time to assess the standard of the existing records with a view to identifying areas for improvement and staff development. The new nursing records should reflect the involvement of patients in planning and making choices and decisions about their care and treatment. Evaluations of nursing care should include patients' views about their progress, any negotiated changes in the care plans and results of these changes. Records should record the fact that patients were given the opportunity to talk about their situation. The existing records identified problems that had arisen and actions taken to rectify them. The records were written clearly so that text could not be erased. All entries were accurately dated and the time of entry should also be recorded. While the inputs were signed in full, block letters alongside the signatures should be recorded to allow easy identification of the professional making the entry.

The service should consider the introduction of a primary nursing system where each patient would be allocated a nurse directly responsible for their care at ward level on a day-to-day basis. The nurse would be responsible for nursing care plans, nursing documentation and for the presentation of clinical aspects of a patient's condition at multidisciplinary review meetings. To facilitate this, all staff members should wear identification badges indicating their role within the professional team.

Thirty-seven in-patient beds were subvented by the Eastern Regional Health Authority (ERHA) and utilised by the Area 3/St James's Mental Health Service, primarily by patients of the Later Life Psychiatry Service. In addition, a day centre provided a variety of sheltered and support activities for day patients from the catchment area 3 community service. The day hospital for the Later Life Psychiatry Service (Martha Whiteway) was also located on the St Patrick's Hospital campus. The standard of all theses facilities was satisfactory. Educational programmes on the conversion of Irish pounds to Euros should be introduced particularly in the day centre and at some of the long-stay wards in St Patrick's. Information packs for the public were available from the Euro Changeover Board of Ireland and these could be used as an educational resource.

A number of voluntary patients in the new Dean Swift Unit and in Grattan Ward were interviewed to ascertain their views of the level of service provided. It was envisaged that this might highlight areas where the service needed to make changes in response to patients' wishes. Patients were satisfied with the courtesy and helpfulness of staff and with the general admission process to the hospital and they felt they had adequate access to the service when required. All of the patients interviewed knew the name of their consultant psychiatrists and felt they had adequate access to them. Patients were generally satisfied with all aspects of privacy and dignity relating to their care and with the cleanliness of the toilets and bathrooms. They felt that the ward environment was cheerful, homely, safe and reassuring and they described the decor as well-kept with modern furnishings. Patients had easy access to telephones and to hot and cold drinks as required. While patients reported having adequate contact with nursing staff, all would like the idea of having a primary nurse responsible for their care whilst hospitalised. All of the patients reported an active involvement in decisions affecting their care and expressed satisfaction that they had not been obliged to repeat information about themselves to different professionals involved in their care. One patient reported that the new ward was very noisy and located a long distance away from the shop. The shop was fifteen yards from this ward.

Since the previous inspection, computers had been introduced to ward areas and a member of staff was appointed to facilitate the education of staff on their use. Nursing documentation, medical chart tracing and discharge summaries were all under review at the time of inspection and the ward policy and procedure manual had been extensively reviewed and updated. A post-ECT checklist was being prepared. A number of seminars on quality assurance had been held in the hospital during the year and the continued registration of St Patrick's Hospital under the mental health legislation was recommended.

ST PATRICK'S HOSPITAL — SECOND 2001 INSPECTION

INSPECTED ON 27 NOVEMBER, 2001

GENERAL COMMENTS

St Patrick's Hospital was a private hospital which drew its patient base from the entire country and cared for both privately and publicly funded patients. In a somewhat unusual arrangement, it also provided community-based services for the St James's Hospital Area 3 service on a contract basis. St James's itself provided an acute psychiatric in-patient base for Area 3. Therefore, there was a close working relationship between the two services and the consultants in the Area 3 service had offices in St Patrick's Hospital. St Patrick's also provided in-patient accommodation for approximately thirty-five older long-stay public patients from the Area 3 service. They were accommodated in Sheridan and Emmet Wards, which also accommodated some private patients.

St Patrick's Hospital had been extensively remodelled, extended and refurbished in recent years. This had resulted in a very high standard of patient accommodation and a good

working environment. Accommodation was provided in four female, three integrated and two male units. Four units served an admission function, one catered for longer-stay patients, one was a continuing care in-patient unit for older persons from the Area 3 public service, one provided, inter-alia, for eating disorders and mother-and-baby psychiatry and the final unit was a pre-discharge ward for patients suffering predominantly from substance dependence. The Dean Swift unit, the most acute of the admission wards, opened in December, 2000 and was of bright and modern design. In addition, a day hospital located in the heart of St Patrick's served older persons in the Area 3 catchment area. There were 265 patients in the hospital on the day of inspection and thirty-four were public patients.

The provision of community services by St Patrick's for Area 3 was an anomalous situation and the Inspectorate felt that the two services should be separate. St James's Hospital should provide and staff its own community services to complement its in-patient activities and to ensure continuity. Similarly, the provision of a day hospital for psychiatry in the grounds of St James's General Hospital would be preferable to the present arrangement of having this facility in a psychiatric hospital.

It was proposed to increase the number of admission wards in St Patrick's so that all wards would be admission wards except the Sheridan and Emmet Units. This would facilitate the allocation of acute wards to individual consultants and would, in effect, build up specialist units with a multidisciplinary team in each ward. It would lead to a more rational arrangement of in-patient care and would ease the allocation of nursing staff to the multidisciplinary teams. It would also advance primary nursing care arrangements, which had already begun. It was hoped to incorporate a day hospital into the hospital building as part of this process. The Inspectorate felt a free-standing arrangement would be preferable.

There had been some nurse shortages in St Patrick's during the year and there were twenty-eight vacancies on the day of inspection. However, efforts were being made to recruit staff from abroad. The matter would be alleviated if it were possible to recruit nurses' assistants or care assistants but the nursing unions had prevented this. Nursing care plans had been in use since the 1980s and a nursing practice development co-ordinator had been appointed to facilitiate the development of nursing practice. A management of violence and aggression programme had been introduced and was underway on the day of inspection. It aimed to improve and make safer the management of aggression and violence.

Case note presentation and documentation was generally satisfactory, although inspection of admission entries revealed that history-taking and care programme planning was less than satisfactory in some instances. The deficits in the prescribing procedures noted in April had been rectified. A seclusion room had been provided in the Dean Swift acute unit but had not been used. A nursing advisory expert had been consulted about this room and a set of recommendations on its use had been made. Up to the present, the room had not been perceived as necessary.

Overall, accommodation at St Patrick's Hospital was of a high standard and stood in contrast to some of the accommodation in older public mental hospitals. The Patients' Charter of St Patrick's had been updated at the time of the last inspection and was prominently displayed in each ward. A standby generator had been provided for the hospital approximately a year ago in case of emergency power cuts.

ST EDMUNDSBURY HOSPITAL, DUBLIN 8 — FIRST 2001 INSPECTION

INSPECTED ON 15 MAY, 2001

IN-PATIENT CARE

In-patient care was provided at St Edmondsbury Hospital, Dublin where fifty beds were provided.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	5	8	5	—	18	85.71
3-12 Months	—	—	1	1	1	—	3	14.29
1-5 Years	—	—	—	—	—	—	—	—
> 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	—	6	9	6	—	21	100
% of Total	—	—	28.57	42.86	28.57	—	100	

In-patient Population Diagnosis (31.12.00)

This information was not provided.

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	6	15	21
Temporary	—	—	—
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	6	15	21

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 420
Number of first admissions in 2000 146
Number of discharges in 2000 422
Number of deaths in 2000.....0

Legal status of admissions
Voluntary.....100%
Non-voluntary 0%

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
*	*	14.5	7	4*

*Included in the statistics for St. Patrick's Hospital

GENERAL COMMENTS

St Edmundsbury Hospital, founded in 1898, was a private hospital specialising in the treatment of psychiatric disorders. The hospital comprised two main buildings; the period residence which housed the various therapeutic areas and a modern carvery kitchen and dining areas and a comparatively modern building which provided the sleeping accommodation. Since the previous inspection, the entrance foyer of the modern building and the corridor linking the two hospital components had been completely refurbished. The corridor had been tastefully redecorated and the new ceramic floor tiles were attractive. An added facility included a wheelchair accessible entrance ramp. Sleeping accommodation comprised three double rooms and forty-four single rooms. The carpets had been removed from all of the bedrooms and replaced with teak flooring.

Consultant psychiatric cover was provided by staff from St Patrick's Hospital and general medical services were provided by a visiting GP. No social workers were attached to the service but a full-time psychologist was employed, apart from a half day spent at St Patrick's Hospital. Other care workers included a counsellor, a family therapist and an employment co-ordinator. Nursing staff comprised a senior nursing officer, two nursing officers, five staff nurses and 6.5 basic grade nurses.

There were forty-eight patients, thirty-eight female and ten male, in St Edmundsbury on the day of inspection. The patients seemed to be happy and contented and there were plenty of group activities. A number of case-notes were inspected and the quality of the inputs was satisfactory. A full fire drill was carried out every six months and the alarm system was tested each month. The overall standard of care was very high and the staff were to be commended for this. The continued registration of St Edmundsbury as an approved institution under the mental treatment legislation was recommended.

ST EDMUNDSBURY HOSPITAL, DUBLIN 8 — SECOND 2001 INSPECTION

INSPECTED ON 10 DECEMBER, 2001

GENERAL DESCRIPTION OF THE SERVICE

There were forty-eight voluntary patients in St Edmundsbury on the day of inspection, forty-two female and six male. There were over 500 admissions to the hospital in 2000. Apart from three double bedrooms, all sleeping accommodation was provided in single

rooms. In addition to nursing staff, sessions were provided by a psychologist, an occupational therapist, a behavioural psychotherapist, a masseur and other ancillary staff. Medical cover was provided by consultants from St Patrick's Hospital who looked after their own patients during the day with a covering consultant at night. A local general practice provided cover for physical illness.

ST JOHN OF GOD HOSPITAL — FIRST 2001 INSPECTION

INSPECTED ON 25 APRIL, 2001

IN-PATIENT CARE

In-patient care was provided at St John of God Hospital which provided 195 beds in six integrated wards.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	5	28	24	5	12	74	85.06
3-12 Months	—	—	3	3	—	3	9	10.34
1-5 Years	—	—	1	3	—	—	4	4.60
> 5 Years	—	—	—	—	—	—	—	—
All Lengths of Stay	—	5	32	30	5	15	87	100
% of Total	—	5.75	36.78	34.48	5.75	17.24	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
4	10	—	27	22	8
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
2	12	1	—	1	87

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	40	44	84
Temporary	1	2	3
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	41	46	87

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 1,140
Number of first admissions in 2000 479
Number of discharges in 2000 1,144
Number of deaths in 2000 2

Legal status of admissions
Voluntary 96.4%
Non-voluntary 3.6%

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
11	20.5	90	60	18.6

GENERAL COMMENTS

Eighty-seven private patients were accommodated in the hospital at 31 December, 2000. In addition, the hospital provided public in-patient facilities for Dublin South East (Catchment Area 1 and part of Area 2) which had its administrative headquarters at the Cluain Mhuire Service, Blackrock. There were forty-one public patients in the hospital at the end of 2000 bringing total in-patient numbers to 128 at the end of the year.

In June, 2000, the hospital commenced the construction of a new fifty-bed acute admission unit which was to be sub-divided into two twenty-five bed nursing units. An additional floor was being added to the existing St Paul's and St Peter's Units and building work was well underway at the time of inspection. It was anticipated that the admission unit would be ready for occupation in August/September, 2001 and it was hoped these enhanced facilities would relieve the long waiting lists experienced by the hospital over the past number of years. It was intended to close two wards in the long-stay area of the hospital to facilitate the opening of the new admission unit. The new unit should deal with the observation difficulties in relation in St Camillus Unit which have been referred to in previous reports.

Like other hospitals in the Eastern Region, St John of God Hospital was encountering difficulties recruiting staff, especially nursing, catering and household staff. Due to the strength of the economy and the consequent low level of unemployment, the response to advertisements in Ireland was reported as disappointingly poor. The hospital had embarked on extensive recruitment campaigns for nurses in Scotland and the Philippines and for household and catering assistants in Spain. These campaigns were reasonably successful but the hospital was experiencing some difficulty retaining staff because of the high cost of accommodation in the catchment area. The continuing decline in the number of nursing staff employed at the hospital resulted in a decision to close the adolescent unit in March, 2000 and this unit remained closed at the time of inspection. However, it was hoped to re-open this unit as soon as a sufficient number of suitably qualified staff were employed.

The introduction of the new nurse training programme and the phasing out of the apprenticeship model of training had contributed to the overall nursing shortages at this and other hospitals. The shortages were also compounded by staff leaving the Dublin region

to work in provincial services where accommodation costs were cheaper. Staffing difficulties had resulted in an inability on the part of the hospital to accept referrals in the normal manner and this, in turn, resulted in lengthy waiting lists throughout the year and the loss of many acute referrals. This situation was reflected in the annual statistics for 2000 which showed a decrease in the total number of admissions to the hospital, a decrease in the average daily occupancy, a decrease in first admissions and an increase in the average length of stay. On this inspection, the results of the intensive international recruitment effort were evident, with staff of various different nationalities now working in different components of the service. They seemed to be happy in their roles and were integrating well into the hospital.

There were thirty-two episodes of seclusion involving twenty patients in 2000. A seclusion register was maintained and fifteen-minute seclusion observations by nursing staff were appropriately recorded. Special one-to-one nursing supervision was used at St John of God Hospital but a system of prescribed recorded observation where patients were observed every fifteen or thirty minutes was in place. A patient observation level chart was recorded for all patients on prescribed observation. Forty-five patients were prescribed ECT in 2000 and facilities for ECT were very satisfactory. The ECT consent form contained a protocol for consent to ECT and the accompanying anaesthetics and was satisfactory. There was a detailed ECT record form and a medical anaesthetic checklist prior to ECT. This checklist contained details of medical history, physical examination, clinical information and concurrent medication. This was satisfactory. Staff at the hospital were designing a nursing checklist for pre- and post-ECT nursing observation. It was hoped this would be operational on the next inspection. An ECT fact sheet for patient information and reference was available.

Twenty-two temporary patients were in the hospital on the day of inspection. Eighteen were public patients from the Cluain Mhuire Service and seven were private patients. Three temporary patients were absent on trial. All of the temporary forms were inspected and any extensions of temporary forms appeared to be satisfactory. Seven registered complaints/appeals were made by patients and relatives to the Local Complaints/Appeals Manager in 2000 and all appeared to have been dealt with satisfactorily. Information on the number of accidents to patients/staff and the number of assaults on patients by other patients and assaults on staff should be compiled so that appropriate tracking and trending of accidents and assaults can take place. An accident and incident reporting form was completed satisfactorily following accidents, incidents and assaults and, by tracking and trending these forms on a periodic basis, insights may be made which could help reduce their number.

A comprehensive, attractive and well-laid out annual report for the hospital was produced each year. The latest report set out objectives for 2001. The written drugs policy and procedure at the hospital was recently reviewed and updated. A number of individual patient prescriptions were checked and it was noted that some prescriptions were difficult to read. Drug allergies were recorded and information was rapidly available to staff. Not all prescriptions were signed and dated individually. Discontinued drugs should be signed off using the discontinuation column. This was not always done and the system of drawing

a line through discontinued drugs and not completing the discontinued column required attention. There was also an increased risk factor in a number of prescriptions where discontinued prescriptions exceeded the number of current prescriptions. These cards should be rewritten. One date and one full signature should be entered for each prescription. Information given to patients about their medication, treatment and any alterations should be recorded in the patients' case notes. Ideally, both written and verbal information on medication should be provided before patients start treatment. This should include details of the effects and likely side-effects of the medication.

A number of clinical files were examined during the inspection. Admission notes were satisfactory; pathways to admission were clearly documented as was a history of the presenting complaint, past history, personal history, family history, patient's current medication and dose, mental state examination, a clear summary and immediate management plan. All of this was satisfactory. Diagnoses were clearly and unambiguously recorded on the notes inspected. The notes were legible and reasonably easy to follow. While the date of each entry was recorded, the time should be entered and all notes should be signed in full with the name of the professional making the entry in blocked capitals beside the signature. The designation should be clearly stated. A physical examination was conducted on all patients, with one exception on the notes inspected. There was a need for written instructions on filing documentation within the medical records and some standard system of continuation page should be used. Different sizes of unprinted notepaper made the notes bulky and untidy. A system should be put in place to record patients' names on each continuation page. All major diagnostic and therapeutic procedures and their results were clearly recorded in the notes inspected. Generally, the file covers were in good condition and inputs from psychologists, social workers, occupational therapists and other professionals were appropriately recorded and formed an integral part of the clinical file. A discharge note was sent to the patient's GP on the day of discharge and copies of the pre-discharge assessment form were available.

The 'Oram nursing model' was used in St John of God Hospital and all staff had appropriate training on the nurse care planning system. Care plans were usually reviewed every three days in the acute admission areas and weekly in other locations. The patient's primary nurse was entered in the nursing record and patients were introduced to their primary nurse each day. Overall, the standards were satisfactory. Records examined identified problems that had arisen and action taken to rectify them. Notes were written in black ink which made them readable on photocopies and no alterations or additions were noted. The record of one patient on an eating disorders programme at St Peter's Unit reflected the involvement of the patient in planning and making of choices and decisions about care and treatment. The records contained information about patients' wishes, preferences and suggestions about treatment approaches. Nursing records should reflect the involvement of patients in planning and making choices about care and treatment. Similarly, evaluations of the nursing care plan should include patients' views about progress and any negotiated changes in the plans and results of changes.

A number of patients were interviewed to ascertain their views on the level of care provided with a view to obtaining suggestions for improvement in care provision. Patients

were satisfied with the courtesy and helpfulness of staff and with the admission procedures. All of the patients knew the name of their consultant psychiatrist and had access to them twice a week. They were satisfied with the information given to them by their doctor in relation to their medical condition, including medication and treatment. All reported understanding what was explained to them. Information relating to patients rights under the Mental Treatment Act, 1945 were prominently displayed in all clinical areas and some patients had read the displayed notices. Patients were generally satisfied with the quality and quantity of food provided but one patient requested a better selection. They were satisfied with aspects of privacy and dignity relating to their care and with the hygiene levels in the toilets and bathrooms. All of the patients had adequate storage space for clothing and personal belongings and access to facilities to wash their personal clothing. The patients felt there was adequate respect for privacy when being giving treatment or advice but one patient disliked the idea of the consultant visiting with the medical team and would prefer access to the doctor on an individual basis. Patients generally found the ward environments cheerful, homely and supportive. The ward decor and furnishings were described as well-kept and modern.

Patients reported access to occupational therapy groups but one patient reported that, over the prolonged Easter Bank Holiday when the occupational therapy unit was closed, there was no access to recreational facilities which made the weekend long and boring. All patients were aware of the primary nursing system and knew their primary nurse. All patients had unrestricted access to the grounds and fresh air and were involved in all decisions affecting their care. The patients interviewed felt they were receiving appropriate care whilst hospitalised. Patients were generally satisfied that there was adequate communication between the different professionals responsible for their care as they had not been obliged to repeat information about themselves to different professionals. One patient in St Peter's felt that the environment had improved significantly since a previous admission but would like access to coffee- and tea-making facilities similar to those available in St Camillus Unit. One patient requested more information about Voluntary Health Insurance and information on access to the stress clinic for in-patients at the hospital.

Overall, the standard of decor, furnishings, hygiene and professional care at St John of God Hospital was satisfactory and its continued registration under the mental health legislation was recommended.

ST JOHN OF GOD HOSPITAL — SECOND 2001 INSPECTION

INSPECTED ON 4 DECEMBER, 2001

There were 151 patients in the hospital on the day of inspection. Thirty were temporary and forty were public patients from the Cluain Mhuire catchment area service.

GENERAL COMMENTS

St John of God Hospital, Stillorgan provided in-patient care for private patients from the entire country and for patients from the Cluain Mhuire catchment area (Area 1 and part

of Area 2) who required in-patient care. Private patients outnumbered public patients by approximately three to one. No distinction was made within the hospital on the level of service and accommodation accorded to both groups. The increase in the number of medium-dependency beds will reduce the need to transfer patients from one ward to another during their in-patient stay. However, it was noted that public (Cluain Mhuire) patients would not be accommodated in the new admission unit. The medical teams were distinct. One group served the private hospital and the other was responsible for the Cluain Mhuire catchment area patients. A day hospital for the Cluain Mhuire catchment area was incorporated on the ground floor of the hospital adjoining the OT department. This was a busy unit and served both pre-discharge Cluain Mhuire patients from the main hospital, catchment area patients from the residences run by the service and those attending from their own homes.

The major current initiative at St John of God Hospital was the new fifty-bed admission ward on the third floor, which was nearing completion. It was scheduled to open at the end of January, 2002. It was of the highest standard in terms of construction, materials and furnishings and comprised a twenty-five bed acute unit and a twenty-five bed sub-acute unit. When it opens, further changes in the arrangement of care within the hospital will ensue and a task force had been working on the re-configuration which would take place. As a first step towards occupancy of the unit, the patients in St Anne's Ward would move to the sub-acute component of the new unit. Provision for a day hospital, day ward, or five-day ward for the private service was one of the issues being considered by the task force in its deliberations.

The assignation of public and private patients within the hospital appeared to work well and a high level of accommodation and care was afforded to the Cluain Mhuire patients. The day hospital operation for Cluain Mhuire patients obviously served a useful purpose but it was argued that such a provision should be community- rather than hospital-based. Overall, the standard of accommodation in St John of God Hospital was high and would be further enhanced when the new unit opened.

BLOOMFIELD HOSPITAL, DONNYBROOK — FIRST 2001 INSPECTION

INSPECTED ON 4 MAY, 2001

GENERAL DESCRIPTION OF THE SERVICE

The Bloomfield complex comprised three constituent parts; Westfield, New Lodge and Bloomfield. Only Bloomfield Hospital was registered as a psychiatric facility under the Mental Treatment Act, 1945 and therefore subject to inspection by the Inspectorate for Mental Hospitals. The original Bloomfield House belonged to the family of the patriot, Robert Emmet, and it was purchased by the Society of Friends (Quakers) at the beginning

of the nineteenth century. It opened as a hospital to cater for the mentally ill in 1812. It has gradually evolved into a unit catering specifically for the psychiatry of later life.

IN-PATIENT CARE

In-patient care was provided at Bloomfield Hospital where forty-four beds were provided in one integrated ward.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	—	3	2	3	8	18.18
3-12 Months	—	—	—	—	3	6	9	20.45
1-5 Years	—	—	—	2	9	4	15	34.10
> 5 Years	—	—	—	3	4	5	12	27.27
All Lengths of Stay	—	—	—	8	18	18	44	100
% of Total	—	—	—	18.18	40.91	40.91	100	

In-patient Population Diagnosis (31.12.00)

This information was not provided.

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	24	18	42
Temporary	—	—	—
P.U.M.	—	—	—
Ward of Court	1	1	2
Total	25	19	44

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 21
Number of first admissions in 2000 21
Number of discharges in 2000 3
Number of deaths in 2000 11

Legal status of admissions
Voluntary 90.5%
Non-voluntary 9.5%

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
1	3.5	18	3	—

GENERAL COMMENTS

Thirty-seven patients, twenty-one male and sixteen female, were in Bloomfield Hospital on the day of inspection. Two were Wards of Court and the remainder were voluntary. A large number were subvented by the Eastern Regional Health Authority and most suffered from Alzeimer's Disease/Dementia. As a result, it was difficult to select suitable patients to interview for their views of the level of service provided. However, two male patients who were interviewed praised all aspects of the service.

A number of case notes were examined and they were quite satisfactory. Medical inputs were frequent and sufficiently detailed and all laboratory tests and reports were neatly filed. Nursing inputs were kept separately in a kardex system and, while inputs were frequent, they were somewhat sparse. The Department of Health and Children Guidelines on Good Practice and Quality Assurance in Mental Health Services were prominently displayed.

Medical cover was provided by a medical superintendent and two visiting psychiatry of later life consultants as requested. Physiotherapy and occupational recreational therapy were organised on a part-time basis. Voluntary organisations and individuals visited frequently and provided music sessions, dancing etc. On the day of inspection, the nursing staff comprised the matron, deputy matron, a staff nurse and four nurses' aides. One staff nurse and two nurses' aides provided night cover.

Bloomfield had been fortunate in having recruited twelve Filipino nurses to the hospital complex and six were assigned to the psychiatric component. They had qualified as nurses in the Philippines and were graded as pre-registration aides in Ireland. One of the nurses was interviewed and she expressed the view that all the nurses were extremely happy at Bloomfield. They had excellent living quarters in the hospital's nurses' home. Each nurse had a single bedroom with a communal sitting-room and cooking facilities.

Over the past few years, the number of patients had gradually reduced and the thirty-seven patients were now accommodated in an integrated Martha/Luke's Unit. The Martha Unit served as the day area and the Luke's Unit downstairs served as the dormitory area. It was envisaged that an entirely new complex would be built in the Rathfarnham area in the next few years and the Bloomfield Complex would be sold to finance the new facility. In the meanwhile, the standard of care and decor remained high and the continued registration of Bloomfield Hospital under the mental health legislation was recommended.

BLOOMFIELD HOSPITAL — SECOND 2001 INSPECTION

INSPECTED ON 7 DECEMBER, 2001

GENERAL COMMENTS

The hospital comprised two integrated units, St Martha's and St Luke's. However, St Luke's was used only as sleeping accommodation, while St Martha's, in addition to providing sleeping and day accommodation for its own patients, also provided day accommodation for patients from St Luke's. The sleeping accommodation in St Martha's was provided in single rooms and one three-bed room in two corridors at right angles to each

other. The main day area was in the middle. The unit had been painted in the past three months and St Luke's was to be painted shortly after the inspection. The sleeping accommodation in St Luke's was provided in double, three-bed and four-bed rooms, and one six-bed unit. Patients remained in the day area all day and there were no organised activities for them. Virtually all of them suffered from organic brain disorder, mostly Alzheimer's disease.

There were thirty-six patients, nineteen male and seventeen female, in Bloomfield Hospital on the day of inspection. All were over sixty-five years of age. Two patients were Wards of Court and the remainder were voluntary. Staff comprised the matron, deputy matron, seven staff nurses, ten nurses' aides and four part-time staff. One staff nurse and two nurses' aides were on duty at night. Contract staff were used for cleaning and cooking.

Around twenty beds were the responsibility of the later-life psychiatry service for Areas 6 and 7 in North Dublin and the remainder were the responsibility of the Cluain Mhuire, Area 1 later-life psychiatry service. The majority of recent referrals had come from Areas 6 and 7. Medical care was provided by a GP, but the later-life psychiatry service was available on request. Fire prevention and safety arrangements were satisfactory. Fire orders were in place and an organised fire drill took place twice a year. The fire extinguishers had been checked in the recent past and staff were confident that there would be a speedy evacuation in the event of a fire. It was understood that Bloomfield had been sold to a developer who would build a new hospital on a green-field site in Rathfarnham.

HIGHFIELD AND HAMPSTEAD HOSPITAL — FIRST 2001 INSPECTION

INSPECTED ON 19 JUNE, 2001

GENERAL DESCRIPTION OF THE SERVICE

Hampstead and Highfield Hospitals comprised two of the four components of the Eustace Hospital Complex which was sited on the north-side of Dublin City straddling the main Dublin-Belfast motorway. Hampstead and Highfield came within the remit of the Inspector of Mental Hospitals as they were designated as approved psychiatric facilities under mental treatment legislation.

IN-PATIENT CARE

In-patient care was provided at Highfield and Hampstead Hospital which had a total of 87 beds in one male and one female unit.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	3	2	2	1	8	11.27
3-12 Months	—	—	—	2	5	9	16	22.53
1-5 Years	—	—	—	2	7	23	32	45.07
> 5 Years	—	—	—	4	3	8	15	21.13
All Lengths of Stay	—	—	3	10	17	41	71	100
% of Total	—	—	4.23	14.08	23.94	57.75	100	

In-patient Population Diagnosis (31.12.00)

Organic Psychosis	Schizophrenia	Other Psychosis	Depressive Disorders	Mania	Neurosis
36	7	—	—	2	16
Personality Disorder	**Alcoholic Disorders**	**Drug Dependence**	**Intellectual Disability**	**Unspecified**	**All Diagnosis**
4	5	—	1	—	71

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	29	34	63
Temporary	—	—	—
P.U.M.	—	—	—
Ward of Court	4	4	8
Total	33	38	71

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 69
Number of first admissions in 2000 27
Number of discharges in 2000 59
Number of deaths in 2000.....24

Legal status of admissions
Voluntary.....100%
Non-voluntary 0%

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
1.2	3.5	48	18	—

HAMPSTEAD HOSPITAL

The building essentially comprised a three-storey period residence with a two-storey custom-built hospital extension which was added on to the northern aspect at a later date. The period residence had a small flat on the upper floor which was occupied by one female patient. She was the only female patient in Hampstead. The middle floor comprised

a lovely sitting-room and dining-rooms overlooking the gardens and farm. The ground floor had an entrance foyer, a matron's office and a visitors' room. The two-storey extension was divided into the upper and lower corridors. The lower corridor had the food preparation area, the main kitchen, the boiler room, a smoking room, a staff changing room and dining-room and the patients' bedrooms, sitting rooms, toilets, etc. The upper corridor area comprised the patients' bedrooms, bathrooms, toilets and a spacious sitting room.

Each of the corridor areas accommodated fifteen older male patients. Some of the patients were sitting out in the garden at the time of inspection, while others were in the sitting-rooms. The entire hospital had been re-painted and modern furniture had been provided and the standard of hygiene and decor had been enhanced. There was little evidence of purposeful activity but the older age profile of the patients made it doubtful they could participate to any meaningful degree. Those patients strolling or sitting in the garden were obviously enjoying themselves. Hampstead had forty-one admissions during 2000. Twenty-one of these were diagnosed as suffering from Alzheimer's disease, fourteen were suffering from vascular dementia, three were intellectually impaired and the remainder suffered from affective disorders.

There were two shifts during the day with one staff nurse, one matron and six carers. At night, one staff nurse and two carers were on duty. Many of the staff were from abroad, including six from the Phillipiness and two from Poland. A number were interviewed and said they were very happy with the treatment they were receiving. They had excellent accommodation in a separate residence on the hospital campus. On the previous inspection, there had been a fire in the electrical system in the basement. Since then, the entire unit had been re-wired with heavy duty wiring. Fire precautions were satisfactory and a complete fire alarm system was in place. The last full fire drill and lecture for all staff was in December, 2000 and another was imminent.

HIGHFIELD HOSPITAL

Highfield Hospital catered for female patients and it was located on the south side of the Dublin-Belfast road. As described in previous reports, the building was a split-level construction with a ground floor, first floor and second floor from the front aspect and two levels to the rear. The main entrance was quite imposing and spacious. To the front, the ground level comprised a central porch and foyer, a spacious dining-room and sitting-room, a visitors' room, a kitchen, a matron's office, an activities room and one two-bed room. At the rear of the house on the ground floor, there were three single bedrooms, three double bedrooms, three toilets and a small enclosed yard with surrounding corridors with a kitchen, pantry, laundry room, sewing room, chef's office, staff dining-room and a bathroom. On the first floor to the front of the house, there was a middle landing with one two-bed room, one four-bed room and two three-bed rooms on the northern aspect and a dining-room, sitting-room, toilet and wheelchair storeroom on the southern aspect. An external fire escape was also provided. At the rear of the house, there were six single bedrooms, three two-bed rooms, a parker bathroom, two toilets, a sluice room and linen storerooms. There were seven single bedrooms, two double bedrooms and a fire exit on the top floor.

Forty-five patients were accommodated in Highfield on the day of inspection. Three were wards of court and the remainder were voluntary. The majority of patients were over seventy years of age. The premises was inspected just before lunch so most of the patients were in the sitting-rooms or heading towards the dining-room. All of the patients were extremely well-dressed and they appeared to be happy. They had just completed an arts and crafts session and seemed more suited to such activities than their male counterparts in Hampstead.

Staff comprised the senior nurse administrator who had one staff nurse and eight carers during the day and one staff nurse and four carers at night. A large number of staff were recruited from abroad and, like those in Hampstead, they were pleased with their conditions of employment and their accommodation.

The patients had access to fine grounds and in nice weather this was appreciated. The standard of hygiene, decor and general patient care was high and the continued registration of Highfield and Hampstead as an approved psychiatric facility under the mental treatment legislation was recommended.

HIGHFIELD AND HAMPSTEAD HOSPITALS — SECOND 2001 INSPECTION

INSPECTED ON 12 DECEMBER, 2001

HIGHFIELD HOSPITAL

Forty-three female patients ranging from fifty to ninety-four years of age were in Highfield Hospital on the day of inspection. Only three were under sixty years of age. In addition, two day attendees were cared for at Highfield Hospital during the day. Staff comprised two nurses and seven care assistants during the day and one nurse and four care assistants at night. An extension on the ground floor had been built in the past year to provide additional day space for high-dependency patients. This had reduced overcrowding and increased the patients' access to the garden in the summer. Apart from this alteration, and an additional sleeping room downstairs, the accommodation had not changed since the inspection earlier in the year. The day area, which included a smoking room, the sitting room and the dining area were also downstairs. There was a conservatory, which served as an occupational facility and which was staffed by art therapists and others who attended on a sessional basis. Physiotherapists visited the hospital and instructed nursing and care staff on how to help patients who required this input.

Day and sleeping areas were provided on the middle floor which was locked. The day area was much less crowded because some patients from this high-dependency area had been taken down to the new extension on the ground floor. A hairdresser, who frequently visited the hospital, was at work at the time of inspection. There was further sleeping accommodation on the second floor and on the return. There was a chair lift at this level.

The consultant psychiatrist was on duty during the week, with weekend cover provided by other sources. General physical care was provided by a local GP.

HAMPSTEAD HOSPITAL

Thirty-seven patients, ranging from their forties to their nineties, were in Hampstead Hospital on the day of inspection. Some of the younger patients had brain damage from trauma, the majority of the older patients had organic dementia and there were a number of functional psychotic patients. Two were respite care patients, four were Wards of Court and the remainder were voluntary. Approximately five health board patients were accommodated in the hospital. One patient was receiving special nursing care at night on a long-term basis. Staff comprised two nurses and six care assistants, a cook, a kitchen/dining room attendant and two cleaners. There were three laundry staff and a seamstress for the entire hospital campus. Accommodation was arranged on two floors; the main day area and dining room were on the first floor, sleeping accommodation was arranged on either side of the corridor and was mostly in single rooms. There was one five-bed room which had screens and rails around the beds. All clothing was personalised. The ground floor catered for more disturbed patients and it had its own sitting room and sleeping accommodation in a mix of single and larger sleeping units. There had been some redecoration of this area which had brightened it up considerably. The same medical cover arrangements existed as in Highfield.

KYLEMORE CLINIC, DÚN LAOGHAIRE/RATHDOWN — FIRST 2001 INSPECTION

INSPECTED ON 19 APRIL, 2001

GENERAL DESCRIPTION OF THE SERVICE

Kylemore Clinic was a residential-style property located in a lovely garden setting. The authorities had sold a small portion of land for housing development and it was hoped that the proceeds from the sale would go towards the construction of a fifty-four bed nursing home on the hospital site. Kylemore Clinic was originally founded in 1947 to care for patients with psychiatric illness. It gradually evolved into a unit catering for later life psychiatric illness, particularly dementia-type illness such as Alzheimer's disease.

IN-PATIENT CARE

In-patient care was provided at Kylemore Clinic where thirty-seven beds were provided.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	—	—	—	—	—	—
3-12 Months	—	—	1	1	—	3	5	13.51
1-5 Years	—	—	—	7	2	12	21	56.76
> 5 Years	—	—	—	—	—	11	11	29.73
All Lengths of Stay	—	—	1	8	2	26	37	100
% of Total	—	—	2.7	21.62	5.41	70.27	100	

In-patient Population Diagnosis (31.12.00)

This information was not provided.

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	12	24	36
Temporary	—	—	—
P.U.M.	—	—	—
Ward of Court	—	1	1
Total	12	25	37

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 14
Number of discharges in 2000 9
Number of deaths in 2000.....6

Legal status of admissions
Voluntary 100%
Non-voluntary 0%

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
2	2	26	7	2

GENERAL COMMENTS

There were thirty-seven patients in the hospital on the day of inspection. Two were Wards of Court and the remainder were voluntary. Ten patients received subventions from the Eastern Regional Health Authority. There had been two admissions to date in 2001 and both replaced two patients who had died. In the recent past, a section of the clinic which cared for short-stay patients had to be phased out due to the increasing demand for long-stay accommodation.

Psychiatric consultant cover was provided by two visiting psychiatrists, each of whom visited twice a week and general medical services were provided by a visiting physician. Nursing staff comprised a matron, one nursing sister and five staff nurses during the day and two staff nurses at night. They were assisted by sixteen nurses' aides during the day

and six at night. Two male orderlies were also employed. An occupational therapist visited four/five mornings per week and organised house activities (cooking, games etc) and outdoor trips. A physiotherapist and a beautician were also employed on a part-time basis.

Apart from general maintenance work such as painting, replacing floor coverings etc., there had been no structural alterations since the previous inspection. Fire prevention precautions were satisfactory and the accommodation, hygiene and decor was of a high standard. The hospital grounds were used extensively by ambulant patients and were obviously appreciated. The overall standard of care in Kylemore Clinic was satisfactory and its continued registration under the mental treatment legislation was recommended.

KYLEMORE CLINIC, DÚN LAOGHAIRE/RATHDOWN — SECOND 2001 INSPECTION

INSPECTED ON 7 DECEMBER, 2001

GENERAL DESCRIPTION OF THE SERVICE

The Kylemore Clinic was a large and somewhat rambling two-storey over-basement house set in its own attractive and well-maintained grounds. Accommodation extended over many different levels in sleeping units of various sizes, including several double and single rooms. There was adequate day space, a dining-room and a designated smoking area. Food came from the clinic's own kitchen. The clinic had a laundry facility, which catered for smaller items; bed-linen and associated materials were sent to an outside laundry service. The building had been redecorated recently and all areas were clean, neat and comfortable. Nursing staff had been trained in safe-lifting techniques and there was an adequate supply of mechanical hoists and bathing/shower equipment. The evidence suggested that patients were well looked after and drug prescription and administration documentation was satisfactory. A physiotherapist visited twice a week.

Thirty-six patients, twenty-three female and thirteen male, were in the clinic at the time of inspection. Six were supported by the Eastern Regional Health Authority (ERHA). The great majority were over sixty-five years of age. Two were Wards of Court and the remainder were voluntary. Staff comprised the matron and seven staff nurses during the day and two night nurses. Thirteen nurses' assistants worked the day shifts and six assistants worked the night shifts. Medical cover was provided by two psychiatrists and one local GP.

Kylemore Clinic had sold some land recently and it was understood that the money accruing was to be used to improve, and perhaps extend, the existing accommodation. Fire drills were carried out twice a year, staff were familiar with the evacuation procedures and were confident that the building would be evacuated rapidly in the event of any fire or other hazard. All fire extinguishers had been checked recently.

PALMERSTOWN VIEW, STEWART'S HOSPITAL, DUBLIN — FIRST 2001 INSPECTION

INSPECTED ON 23 APRIL, 2001

GENERAL DESCRIPTION OF THE SERVICE

The psychiatric facility at Palmerstown Hospital was originally an eight-bed domestic style residence at the entrance to the hospital. When it closed, Palmerstown View (Bungalow 22) was designated to replace it and it was formally registered as a psychiatric facility under the Mental Treatment Act, 1945 in 1997.

IN-PATIENT CARE

In-patient care was provided in an eight-bed unit at Palmerstown View.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	—	—	—	—	—	—
3-12 Months	—	—	—	—	—	—	—	—
1-5 Years	—	—	3	—	—	—	3	75
> 5 Years	—	—	1	—	—	—	1	25
All Lengths of Stay	—	—	4	—	—	—	4	100
% of Total	—	—	100	—	—	—	100	

In-patient Population Diagnosis (31.12.00) (Dual Diagnosis)

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

Status of in-patients at 31.12.00

Status	Male	Female	Total
Voluntary	4	—	4
Temporary	—	—	—
P.U.M.	—	—	—
Ward of Court	—	—	—
Total	4	—	4

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 5
Number of discharges in 2000 6
Number of deaths in 2000.....0

Legal status of admissions
Voluntary.....100%
Non-voluntary 0%

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
3	0	6	7	3

GENERAL COMMENTS

Palmerstown View was one of a number of residential-style bungalows built specifically for patients with intellectual disability on the grounds of Stewart's Hospital. Its design, furniture, fittings etc. reflected the purpose for which it was built. The unit comprised a spacious day area which was comfortably and appropriately furnished, bedrooms, a dining area and toilet facilities, all of which were to a high standard of hygiene and decor. The bungalow opened out onto a nice garden area which was available for use by the patients. The patients also had access to the main hospital grounds and all the rehabilitation and recreation facilities on the hospital campus.

At the time of inspection, one patient was in seclusion. The medical and nursing records for this patient were examined in detail and seclusion practices in the unit as a whole were also inspected. The implementation of proper seclusion procedures had been the subject of correspondence between the hospital and the Inspectorate in the past. It was noted that this patients had a complete medical assessment the day before the inspection and all protocols for seclusion were written up and planned in advance. The quality of the case notes and the quality of note-taking of both the medical and nursing staff was of a very high standard. The input of psychologists into the case notes was good.

There were only five patients in the residence on the day of inspection and they were all neatly dressed and seemed to be happy. No specific nursing model or key worker system appeared to be in use in the unit. Each patient participated on a behaviour programme. This was organised by the multidisciplinary team but the main input was from the psychologist and the nurse who devised and monitored the programmes. The psychologist called to the unit twice a week and, with the nurse, assessed each patient's progress.

PALMERSTOWN VIEW, STEWART'S HOSPITAL, DUBLIN — SECOND 2001 INSPECTION

INSPECTED ON 10 DECEMBER 2001

GENERAL COMMENTS

Palmerstown View was a six-bed unit for patients with dual psychiatric and intellectual disability diagnoses. There were four voluntary patients in the unit on the day of inspection. The unit needed to be re-painted but otherwise the accommodation was generally satisfactory. There had been thirty-seven episodes of seclusion since 1 July, 2001 involving

four patients but virtually all of them involved one individual who had been discharged back to the district mental hospital from which he came in January, 2001. The medical entries for seclusion were generally initialled rather than signed in full. All entries should be fully signed and legible. In one case, there was no medical signature at all. While this seclusion episode was not recorded in the medical notes, the nursing notes did record that the patient had been placed in seclusion.

LARCH VILLA, BELMONT PARK HOSPITAL, WATERFORD

— FIRST 2001 INSPECTION

INSPECTED ON 25 MAY, 2001

GENERAL DESCRIPTION OF SERVICE

Larch Bungalow was a locked facility and one of several similar bungalows on the campus of Belmont Park Hospital. It was the only facility designated under the Mental Treatment Act, 1945 as a psychiatric facility.

IN-PATIENT CARE

In-patient care was provided at Larch Bungalow where eight beds provided for the mental health needs of persons with intellectual disabilities.

Age and Length of Stay of all Patients at 31.12.00

Age Length of Stay	<15	15-19	20-44	45-64	65-74	>75	All Ages	% of Total
< 3 Months	—	—	—	—	—	—	—	—
3-12 Months	—	—	—	1	—	—	1	12.50
1-5 Years	—	—	2	—	—	—	2	25.00
> 5 Years	—	—	2	3	—	—	5	62.50
All Lengths of Stay	—	—	4	4	—	—	8	100
% of Total	—	—	50.00	50.00	—	—	100	

In-patient Population Diagnosis (31.12.00)

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

Status of in-patients at 31.12.00

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

ADMISSIONS/DISCHARGES AND DEATHS

Number of admissions in 2000 0
Number of first admissions in 2000 0
Number of discharges in 2000 2
Number of deaths in 2000.....0

Legal status of admissions
Voluntary.....100%
Non-voluntary 0%

COMMUNITY FACILITIES

Day Facilities

	Number	No. of Places	No. of persons attending
Day Hospitals	—	—	—
Day Centres	1	35	35
Out-patient clinics	—	—	—

STAFFING

Medical	Administrative	Nursing	Non-nursing	Other professionals
0.24	0.3	5.5	4.84	0.2

GENERAL COMMENTS

A multidisciplinary team approach was used in Larch Bungalow. It was headed by a consultant psychiatrist and other team members included a social worker, a trainee psychologist, a recreational therapist, a visiting physiotherapist and a visiting GP. Two nursing shifts were used each day and a nurse's aide system was in place. The first shift comprised the ward sister, one full-time care staff and one part-time care staff. Shift two comprised one staff nurse, one full-time care staff and one part-time care staff. One nurse provided night cover.

There were thirty-nine episodes of seclusion involving two patients in 2000. All details of seclusion were recorded but it was suggested that an official seclusion book be used for recording seclusion episodes. It was also suggested that the legal regulations governing seclusion be posted up in the unit for the attention of all care workers. The average seclusion period lasted around ten to twelve minutes and patients were continually observed while placed in seclusion.

All of the residents were neatly dressed and the bed clothing was exceptionally clean and comfortable. The whole ambience of the unit was very homely and welcoming and the standards of care, hygiene and decor were of the highest order. The registration of Larch Bungalow as a psychiatric facility under the current mental health legislation was recommended.

LARCH VILLA, BELMONT PARK HOSPITAL, WATERFORD — SECOND 2001 INSPECTION

INSPECTED ON 27 NOVEMBER, 2001

GENERAL COMMENTS

The general layout of this unit remained unchanged and there had been no structural changes since those mentioned in the Inspector's report for the year 2000. Eight patients were in the unit on the day of inspection and one of these was regarded as a crisis intervention case. There had been two patient changes since the first inspection earlier in the year; one female and one male patient were transferred to other units on the hospital campus and two new patients were admitted to Larch Villa. At the time of inspection, six of the residents were engaged in therapeutic activities in other campus units while two were present in the unit because of their behavioural disturbance. As usual, the unit was in an immaculate condition. Bed clothes and patients' clothing were spotlessly clean and the overall ambience of the unit was excellent. Fire precautions and procedures were satisfactory and the continued registration of the unit under the Mental Treatment Act, 1945 was recommended.

APPENDIX 1

Statistics Relating to the Psychiatric Services

APPENDIX 1

TABLE 1.

Number of Patients in Public Psychiatric Hospitals and Units at 31 December 1996-2001 excluding Older Patients and Patients with an Intellectual Disability in De-Designated Wards.

	1996	1997	1998	1999	2000	2001
EASTERN REGIONAL HEALTH AUTHORITY						
St. Brendan's Hospital, Dublin 7	252	190	181	187	177	160
St. Ita's Hospital, Portrane, County Dublin	571	565	507	501	498	452
St. Vincent's Hospital, Fairview, Dublin 3	71	83	72	72	74	72
Psychiatric Unit, Mater Misericordiae Hospital, Dublin 7	14	14	15	8	17	15
Psychiatric Unit, Vergemount, Clonskeagh, Dublin 6	24	25	25	22	21	19
Psychiatric Unit, St. James's Hospital, Dublin 8	81[2]	48	89[2]	75[2]	51	47
Cluain Mhuire Family Centre, Blackrock, County Dublin	35	26	46	57	41	34
Psychiatric Unit, St. Vincent's Hospital, Elm Park, Dublin 4	9	20	20	12	14	10
Psychiatric Unit, James Connolly Memorial Hospital, Blanchardstown, Dublin 15	8	13	15	15	19	15
Newcastle Hospital, County Wicklow	73	69	73	65	63	66
St. Loman's Hospital, Palmerstown, Dublin 20	76	68	74	25	19	20
Psychiatric Unit, Tallaght Hospital[1]	—	—	—	44	38	38
Lakeview Unit, Naas General Hospital, Naas, County Kildare	30	34	28	23	42	33
Central Mental Hospital, Dundrum, Dublin 14	78	83	84	86	79	83
TOTAL	1,322	1,238	1,229	1,192	1,153	1.064
MIDLAND HEALTH BOARD						
St. Fintan's Hospital, Portlaoise	131	125	111	91	97	90
St. Loman's Hospital, Mullingar	236	211	192	187	184	181
TOTAL	367	336	303	278	281	271
MID-WESTERN HEALTH BOARD						
Our Lady's Hospital, Ennis	211	203	194	190	187	146
Acute Psychiatric Unit, Ennis General Hospital[3]	—	—	—	—	—	46
Psychiatric Unit, Limerick Regional Hospital	47	40	46	49	53	46
St. Joseph's Hospital, Limerick	194	191	189	187	184	145
TOTAL	452	434	429	426	424	383
NORTH-EASTERN HEALTH BOARD						
St. Brigid's Hospital, Ardee	131	131	130	120	99	94
Psychiatric Unit, Our Lady's Hospital, Navan	21	17	16	15	18	26
St. Davnet's Hospital, Monaghan	130	109	93	81	67	63
Psychiatric Unit, Cavan General Hospital	19	20	21	13	9	11
TOTAL	301	277	260	229	193	194
NORTH-WESTERN HEALTH BOARD						
Sligo Mental Health Service, Ballytivnan, County Sligo	117	83	68	47	59	47
St. Conal's Hospital, Letterkenny, County Donegal	75	68	70	71	36	36
Psychiatric Unit, Letterkenny General Hospital	58	41	53	48	49	50
TOTAL	250	192	191	166	144	133

	1996	1997	1998	1999	2000	2001
SOUTH-EASTERN HEALTH BOARD						
St. Dympna's Hospital, Carlow	110	109	102	107	95	92
St. Canice's Hospital, Kilkenny	126	122	132	100	107	77
St. Luke's Hospital, Clonmel	236	204	193	187	170	167
St. Michael's Unit, Clonmel	42	45	43	41	50	45
St. Otteran's Hospital, Waterford	137	117	121	120	120	116
Psychiatric Unit, Waterford Regional Hospital, Ardkeen	24	28	34	21	33	41
St. Senan's Hospital, Enniscorthy	192	177	203	186	195	146
TOTAL	867	802	828	762	770	684
SOUTHERN HEALTH BOARD						
Our Lady's Hospital, Cork/St. Michael's Unit, Mercy Hospital[4]	130	118	106	107	100	119
St. Stephen's Hospital, Sarsfield's Court	278	267	276	232	217	209
Psychiatric Unit, Cork University Hospital and St. Finbarr's Hospital	64	88	70	91	85	99
Psychiatric Unit, Bantry General Hospital	19	19	15	13	12	15
St. Finan's Hospital, Killarney	245	227	209	204	179	145
Psychiatric Unit, Tralee General Hospital	46	50	37	38	48	47
TOTAL	782	769	713	685	641	634
WESTERN HEALTH BOARD						
St. Brigid's Hospital, Ballinasloe	427	394	357	323	280	266
Psychiatric Unit, U.C.H., Galway	41	42	46	47	70	42
St. Mary's Hospital, Castlebar	225	200	191	180	170	138
Psychiatric Unit, Roscommon County Hospital	21	14	24	17	13	8
TOTAL	714	650	618	567	533	454
OVERALL TOTAL	5,055	4,698	4,571	4,305	4,139	3,817

[1] The Psychiatric Unit, Tallaght General Hospital, Tallaght, Dublin 24 opened on 2nd August, 1999.
[2] This figure includes patients under subvention by the Eastern Regional Health Authority in St. Patrick's Catchment Area Services.
[3] The new psychiatric unit opened in Ennis General Hospital in December, 2001.
[4] St. Michael's Acute Psychiatric Unit, The Mercy Hospital, Cork opened in April, 2000.

TABLE 2.

Number of Patients in Public Psychiatric Units and Hospitals, Number of Patients with an Intellectual Disability and Number of Older Patients in De-Designated Facilities at 31 December, 2001.

	Psychiatric	Intellectual Disability (De-Designated)	Older Persons (De-Designated)
EASTERN REGIONAL HEALTH AUTHORITY			
St. Brendan's Hospital, Dublin 7	160	—	—
St. Ita's Hospital, Portrane, County Dublin	452	—	—
St. Vincent's Hospital, Fairview, Dublin 3	72	—	—
Psychiatric Unit, Mater Misericordiae Hospital, Dublin 7	15	—	—
Psychiatric Unit, Vergemount, Clonskeagh, Dublin 6	19	—	40
Psychiatric Unit, St. James's Hospital, Dublin 8	47	—	—
Cluain Mhuire Family Centre, Blackrock, County Dublin	34	—	—
Psychiatric Unit, St. Vincent's Hospital, Elm Park, Dublin 4	10	—	—
Psychiatric Unit, James Connolly Memorial Hospital, Blanchardstown, Dublin 15	15	—	—
Newcastle Hospital, County Wicklow	66	—	—
St. Loman's Hospital, Palmerstown, Dublin 20	20	—	54
Psychiatric Unit, Tallaght Hospital	38	—	—
Lakeview Unit, Naas General Hospital, Naas, County Kildare	33	—	—
Central Mental Hospital, Dundrum, Dublin 14	83	—	—
TOTAL	1,064	—	94
MIDLAND HEALTH BOARD			
St. Fintan's Hospital, Portlaoise	90	49	—
St. Loman's Hospital, Mullingar	181	70	—
TOTAL	271	119	—
MID-WESTERN HEALTH BOARD			
Our Lady's Hospital, Ennis	146	20	—
Acute Psychiatric Unit, Ennis General Hospital	46	—	—
Psychiatric Unit, Limerick Regional Hospital	46	—	—
St. Joseph's Hospital, Limerick	145	—	—
TOTAL	383	20	—
NORTH-EASTERN HEALTH BOARD			
St. Brigid's Hospital, Ardee, County Louth	94	—	—
Psychiatric Unit, Our Lady's Hospital, Navan	26	—	—
St. Davnet's Hospital, Monaghan	63	35	29
Psychiatric Unit, Cavan General Hospital	11	—	—
TOTAL	194	35	29
NORTH-WESTERN HEALTH BOARD			
Sligo Mental Health Service, Ballytivnan, Sligo	47	—	—
St. Conal's Hospital, Letterkenny	36	—	16
Psychiatric Unit, Letterkenny General Hospital	50	—	—
TOTAL	133	—	16
SOUTH-EASTERN HEALTH BOARD			
St. Dympna's Hospital, Carlow	92	—	—
St. Canice's Hospital, Kilkenny	77	—	—
St. Luke's Hospital, Clonmel	167	40	—
St. Michael's Unit, Clonmel	45	—	—
St. Otteran's Hospital, Waterford	116	—	—
Psychiatric Unit, Waterford Regional Hospital, Ardkeen	41	—	—
St. Senan's Hospital, Enniscorthy	146	—	—
TOTAL	684	40	—

	Psychiatric	Intellectual Disability (De-Designated)	Older Persons (Non Designated)
SOUTHERN HEALTH BOARD			
Our Lady's Hospital, Cork/ St. Michael's Unit, Mercy Hospital	119	—	—
St. Stephen's Hospital, Sarsfield's Court	209	10	—
Psychiatric Unit, Cork University Hospital and St Finbarr's Hospital	99	—	—
Psychiatric Unit, Bantry General Hospital	15	—	—
St. Finan's Hospital, Killarney	145	27	—
Psychiatric Unit, Tralee General Hospital	47	—	—
TOTAL	634	37	—
WESTERN HEALTH BOARD			
St. Brigid's Hospital, Ballinasloe	266	—	—
Psychiatric Unit, U.C.H., Galway	42	—	—
St. Mary's Hospital, Castlebar	138	—	—
Psychiatric Unit, Roscommon County Hospital	8	—	—
TOTAL	454	—	—
OVERALL TOTAL	3,817	251	139

TABLE 3.

Rate of Hospitalisation per 1,000 of the population at 31 December, 1999-2001.

	1999	2000	2001
EASTERN REGIONAL HEALTH AUTHORITY			
St. Brendan's Hospital, Dublin 7 St. Ita's Hospital, Portrane, County Dublin St. Vincent's Hospital, Fairview, Dublin 3 Psychiatric Unit, Mater Misericordiae Hospital, Dublin 7 Psychiatric Unit, Vergemount, Clonskeagh, Dublin 6 Psychiatric Unit, St. James's Hospital, Dublin 8 Cluain Mhuire Family Centre, Blackrock, County Dublin Psychiatric Unit, St. Vincent's Hospital, Elm Park, Dublin 4 Psychiatric Unit, James Connolly Memorial Hospital, Blanchardstown, Dublin 15	1.1[1]	1.0[1]	1.0[1]
Wicklow Mental Health Services	0.7	0.7	0.7
St. Loman's Hospital, Palmerstown, Dublin 20 Psychiatric Unit, Tallaght Hospital Kildare Mental Health Services	0.2	0.2	0.4
TOTAL	0.8	0.7	0.7
MIDLAND HEALTH BOARD			
Laois/Offaly Mental Health Services	0.8	0.9	0.8
Longford/Westmeath Mental Health Services	2.0	1.9	1.9
TOTAL	1.3	1.4	1.3
MID-WESTERN HEALTH BOARD			
Clare Mental Health Services	2.0	2.0	2.0
Limerick Mental Health Services	1.4	1.4	1.2
TOTAL	1.6	1.6	1.5
NORTH-EASTERN HEALTH BOARD			
Louth/Meath Mental Health Services	0.7	0.6	0.6
Cavan/Monaghan Mental Health Services	0.9	0.7	0.7
TOTAL	0.8	0.6	0.6
NORTH-WESTERN HEALTH BOARD			
Sligo Mental Health Services	0.5	0.6	0.5
Donegal Mental Health Services	1.0	0.7	0.7
TOTAL	0.8	0.7	0.6
SOUTH-EASTERN HEALTH BOARD			
Carlow Mental Health Services	2.6	2.3	2.2
Kilkenny Mental Health Services	1.7	1.8	1.3
Tipperary Mental Health Services	1.7	1.6	1.6
Waterford Mental Health Services	1.3	1.4	1.5
Wexford Mental Health Services	1.8	1.9	1.4
TOTAL	1.7	1.7	1.5

	1999	2000	2001
SOUTHERN HEALTH BOARD			
North Lee Mental Health Services North Cork Mental Health Services South Lee Mental Health Services West Cork Mental Health Services	1.1[(1)]	1.1[(1)]	1.0[(1)]
Kerry Mental Health Services	1.9	1.8	1.5
TOTAL	1.3	1.2	1.1
WESTERN HEALTH BOARD			
East Galway Mental Health Services West Galway Mental Health Services	2.0	1.8	1.6
Mayo Mental Health Services	1.6	1.5	1.2
Roscommon Mental Health Services	0.3	0.2	0.2
TOTAL	1.6	1.5	1.3
OVERALL TOTAL	1.2	1.1	1.0

[(1)] Because of the overlap in hospital catchment areas in Dublin and Cork, these hospitals have been grouped together, except St. Loman's Hospital in Dublin for which separate information is available.

TABLE 4.

Number of Admissions and Admission Rates for the years ending 31 December, 1999-2001.

	Admissions			Rates per 1,000 of Population		
	1999	2000	2001	1999	2000	2001
EASTERN REGIONAL HEALTH AUTHORITY						
St. Brendan's Hospital, Dublin 7	955	914	668			
St. Ita's Hospital, Portrane, County Dublin	789	917	894			
St. Vincent's Hospital, Fairview, Dublin 3	904	714	719			
Psychiatric Unit, Mater Misericordiae Hospital, Dublin 7	263	238	240			
Psychiatric Unit, Vergemount, Clonskeagh, Dublin 6	492	451	346	5.6[1]	5.1[1]	5.2[1]
Psychiatric Unit, St. James's Hospital, Dublin 8[2]	390	428	468			
Cluain Mhuire Family Centre, Blackrock, County Dublin	485	417	417			
Psychiatric Unit, St. Vincent's Hospital, Elm Park, Dublin 4	331	373	284			
Psychiatric Unit, James Connolly Memorial Hospital, Blanchardstown, Dublin 15	242	250	302			
Newcastle Hospital, County Wicklow	612	598	582	6.8	6.7	6.5
St. Loman's Hospital, Palmerstown, Dublin 20	472	55	40			
Psychiatric Unit, Tallaght Hospital	305	627	660	3.5	2.9	3.3
Lakeview Unit, Naas General Hospital, Naas, County Kildare	633	610	719			
TOTAL	6,873	6,592	6,339	5.0	4.6	4.7
MIDLAND HEALTH BOARD						
St. Fintan's Hospital, Portlaoise	672	736	768	6.0	6.6	6.9
St. Loman's Hospital, Mullingar	836	807	844	8.8	8.5	8.9
TOTAL	1,508	1,543	1,612	7.3	7.5	7.8
MID-WESTERN HEALTH BOARD						
Our Lady's Hospital, Ennis/Acute Psychiatric Unit[3]	506	507	502	5.4	5.4	5.3
Psychiatric Unit, Limerick Regional Hospital	830	769	761	5.1	4.7	4.7
St. Joseph's Hospital, Limerick	6	10	7			
TOTAL	1,342	1,286	1,270	5.2	5.0	4.9
NORTH-EASTERN HEALTH BOARD						
St. Brigid's Hospital, Ardee	450	430	420			
Psychiatric Unit, Our Lady's Hospital, Navan	259	280	308	3.6	3.5	3.6
St. Davnet's Hospital, Monaghan	107	66	68			
Psychiatric Unit, Cavan General Hospital	223	158	136	3.2	2.2	2.0
TOTAL	1,039	934	932	3.4	3.1	3.1

	Admissions			Rates per 1,000 of Population		
	1999	2000	2001	1999	2000	2001
NORTH-WESTERN HEALTH BOARD						
Sligo Mental Health Service, Ballytivnan	574	574	690	6.2	6.2	7.5
St. Conal's Hospital, Letterkenny						
Psychiatric Unit, Letterkenny General Hospital	0	0	0	6.6	6.6	7.6
	805	803	921			
TOTAL	1,379	1,377	1,611	6.5	6.5	7.5
SOUTH-EASTERN HEALTH BOARD						
St. Dympna's Hospital, Carlow	321	315	296	7.7	7.6	7.1
St. Canice's Hospital, Kilkenny	511	385	411	8.5	6.4	6.8
St. Luke's Hospital, Clonmel[4]	93	174	129	7.9	9.2	8.3
St. Michael's Unit, Clonmel[4]	978	1,079	990			
St. Otteran's Hospital, Waterford	39	49	43			
Psychiatric Unit, Waterford Regional Hospital, Ardkeen	535	755	737	5.4	7.5	7.3
St. Senan's Hospital, Enniscorthy	552	546	585	5.3	5.3	5.6
TOTAL	3,029	3,303	3,191	6.8	7.4	7.1
SOUTHERN HEALTH BOARD						
Our Lady's Hospital, Cork/ St Michael's Unit, Mercy Hospital	761	1,030	1,171			
St. Stephen's Hospital, Sarsfield's Court	532	523	349			
Psychiatric Unit, Cork University Hospital and St. Finbarr's Hospital	642	688	678	5.3[1]	6.1[1]	5.8[1]
Psychiatric Unit, Bantry General Hospital	300	349	276			
St. Finan's Hospital, Killarney	53	61	60			
Psychiatric Unit, Tralee General Hospital	750	820	837	6.4	7.0	7.1
TOTAL	3,038	3,471	3,371	5.5	6.3	6.1
WESTERN HEALTH BOARD						
St. Brigid's Hospital, Ballinasloe[5]	733	708	655	7.9	7.6	7.8
Psychiatric Unit, U.C.H., Galway	774	745	834			
St. Mary's Hospital, Castlebar	622	628	664	5.6	5.7	6.0
Psychiatric Unit, Roscommon County Hospital	483	446	449	9.2	8.5	8.5
TOTAL	2,612	2,527	2,602	7.4	7.1	7.3
OVERALL TOTAL	20,820	21,033	20,928	5.6	5.6	5.7

[1] Because of the overlap in hospital catchment areas in Dublin and Cork, these hospitals have been grouped together, except St. Loman's Hospital in Dublin for which separate information is available.
[2] This figure includes patients under subvention by the Eastern Regional Health Authority in St Patrick's Hospital Service.
[3] Acute Psychiatric Unit, Ennis General Hospital opened on 8/12/01.
[4] St. Luke's Hospital and St. Michael's Unit, Clonmel served North and South Tipperary.
[5] St. Brigid's Hospital, Ballinasloe accommodates patients from West Galway.

TABLE 5.

Community Residential Accommodation at 31 December, 2001.

	Number of Community Residences	Number of Places	Places per 100,000 Population	Catchment Area Pop.
EASTERN REGIONAL HEALTH AUTHORITY				835,734
St. Brendan's Hospital, Dublin 7	11	74		129,000
Psychiatric Unit, James Connolly Memorial Hospital	11	136		
St. Ita's Hospital, Portrane, County Dublin	15	115		202,157
St. Vincent's Hospital, Fairview, Dublin 3/	9	99		138,000
Psychiatric Unit, Mater Misericordiae Hospital, Dublin 7			67[1]	
Psychiatric Unit, Vergemount, Clonskeagh, Dublin 6	4	40		99,577
Psychiatric Unit, St. James's Hospital, Dublin 8	7	47		97,000
Cluain Mhuire Family Centre, Blackrock, County Dublin	5	50		170,000
Newcastle Hospital, County Wicklow	9	82	91	89,713
St. Loman's Hospital, Palmerstown, Dublin 20	13	125		258,028
Lakeview Unit, Naas General Hospital, Naas, County Kildare	6	52	41	171,000
TOTAL	90	820	61	1,354,475
MIDLAND HEALTH BOARD				
Laois/Offaly Mental Health Services	17	111	99	111,878
Longford/Westmeath Mental Health Services	14	98	103	95,200
TOTAL	31	209	101	207,078
MID-WESTERN HEALTH BOARD				
Clare Mental Health Services	13	121	129	94,006
Limerick Mental Health Services	15	146	88	165,042
TOTAL	28	267	103	259,048
NORTH-EASTERN HEALTH BOARD				
Louth/Meath Mental Health Services	7	78	39	200,074
Cavan/Monaghan Mental Health Services	17	113	110	103,000
TOTAL	24	191	63	303,074
NORTH-WESTERN HEALTH BOARD				
Sligo/Leitrim Mental Health Services	25	175	190	92,000
Donegal Mental Health Services	16	133	110	121,412
TOTAL	41	308	144	213,412
SOUTH-EASTERN HEALTH BOARD				
Carlow Mental Health Services	8	64	154	41,597
Kilkenny Mental Health Services	13	114	189	60,300
Tipperary Mental Health Services	15	80	59	135,620
Waterford Mental Health Services	17	104	98	106,529
Wexford Mental Health Services	18	91	87	104,371
TOTAL	71	453	101	448,417

	Number of Community Residences	Number of Places	Places per 100,000 Population	Catchment Area Pop.
SOUTHERN HEALTH BOARD				425,488
North Lee Mental Health Services	6	64	50[1]	145,233
North Cork Mental Health Services	4	26		75,690
South Lee Mental Health Services	8	42		156,340
West Cork Mental Health Services	9	81		48,225
Kerry Mental Health Services	16	125	99	126,130
TOTAL	43	338	61	551,618
WESTERN HEALTH BOARD				
East Galway Mental Health Services	39	244	159	91,619
West Galway Mental Health Services	11	60		100,000
Mayo Mental Health Services	21	120	108	111,000
Roscommon Mental Health Services	7	67	127	52,726
TOTAL	78	491	138	355,345
OVERALL TOTAL	406	3,077	83	3,692,467

[1] Because of the overlap in hospital catchment areas in Dublin and Cork, these areas have been grouped together.

TABLE 6.

Psychiatric In-Patients in Registered Psychiatric Hospitals at 31 December, 1998-2001.

	1998	1999	2000	2001
Bloomfield Hospital, Dublin	49	38	44	36
Palmerstown View, Stewart's Hospital, Dublin	6	6	4	4
Hampstead and Highfield Hospitals, Dublin	78	73	71	80
Kylemore Clinic, Dun Laoghaire/Rathdown	36	38	37	37
Larch Bungalow, Belmont Park, Waterford	8	6	7	8
St. John of God Hospital, Dun Laoghaire/ Rathdown	111	91	87	83
St. Patrick's Hospital, Dublin (inc. St. Edmundsbury)	200	169	133	191
TOTAL	488	421	383	439

INSPECTORATE OF MENTAL HOSPITALS

SECLUSION RECORD 2001

WESTERN HEALTH BOARD

Hospital & In-Patient Unit	No. of Episodes of Seclusion	No. of Patients Placed in Seclusion
St. Bridget's Hospital Ballinasloe	23	1
University Hospital, Galway Psych. Unit	0	0
St. Mary's Hospital, Castlebar	0	0
Roscommon Mental Health Service	0	0
Total	23	1

SOUTHERN HEALTH BOARD

Hospital & In-Patient Unit	No. of Episodes of Seclusion	No. of Patients Placed in Seclusion
Our Lady's Hospital Cork	8	6
St. Stephen's Hospital	N/A	N/A
Cork University Hospital Psych. Unit	0	27
Bantry Psychiatric Unit	0	45
Tralee General Hospital, Psych. Unit	28	12
St. Finan's Hospital, Killarney	33	9
Total	69	99

SOUTH EASTERN HEALTH BOARD

Hospital & In-Patient Unit	No. of Episodes of Seclusion	No. of Patients Placed in Seclusion
St. Dympna's Hospital, Carlow	665	8
St. Canice's, Kilkenny	N/A	N/A
St. Luke's, Clonmel	99	27
St. Michael's Unit Clonmel	110	45
St. Otteran's, Waterford	11	3
Waterford Regional Hospital Psychiatric Unit	28	15
St. Senan's, Enniscorthy	39	6
Total	952	104

MIDLAND HEALTH BOARD

Hospital & In-Patient Unit	No. of Episodes of Seclusion	No. of Patients Placed in Seclusion
St. Fintan's Hospital	46	22
St. Loman's Hospital	1	1
Total	47	23

NORTH-WESTERN HEALTH BOARD

Hospital & In-Patient Unit	No. of Episodes of Seclusion	No. of Patients Placed in Seclusion
Sligo Mental Health Services	46	9
St. Conal's Letterkenny	0	0
Letterkenny General Hospital Psych. Unit	0	0
Total	46	9

MID-WESTERN HEALTH BOARD

Hospital & In-Patient Unit	No. of Episodes of Seclusion	No. of Patients Placed in Seclusion
Our Lady's Hospital, Ennis	0	0
St. Joseph's Hospital Limerick	49	7
Limerick Regional Hospital	0	0
Total	49	7

NORTH EASTERN HEALTH BOARD

Hospital & In-Patient Unit	No. of Episodes of Seclusion	No. of Patients Placed in Seclusion
St. Brigid's Hospital, Ardee	0	0
Our Lady's Hospital, Navan Psych. Unit	20	9
St. Davnet's Hospital, Monaghan	0	0
Cavan General Unit, Psych. Unit	0	0
Total	20	9

EASTERN REGIONAL HEALTH AUTHORITY

NORTHERN AREA HEALTH BOARD

Hospital & In-Patient Unit	No. of Episodes of Seclusion	No. of Patients Placed in Seclusion
St. Brendan's Hospital	669	178
St. Ita's Hospital	108	62
St. Joseph's Mental Handicap Services	511	37
Mater Hospital Psych. Unit	7	4
St. Vincent's Hospital, Fairview	72	25
James Connolly Memorial Hospital	0	0
Total	1,367	306

EAST COAST AREA HEALTH BOARD

Hospital & In-Patient Unit	No. of Episodes of Seclusion	No. of Patients Placed in Seclusion
St. Vincent's Hospital, Elm Park	0	0
Vergmount, Clonskeagh Psych. Unit	0	0
Newcastle Hospital, Co. Wicklow	106	24
Central Mental Hospital, Dundrum	785	95
St. John of God, Stillorgan & Area 1 Service	5	39
Total	896	158

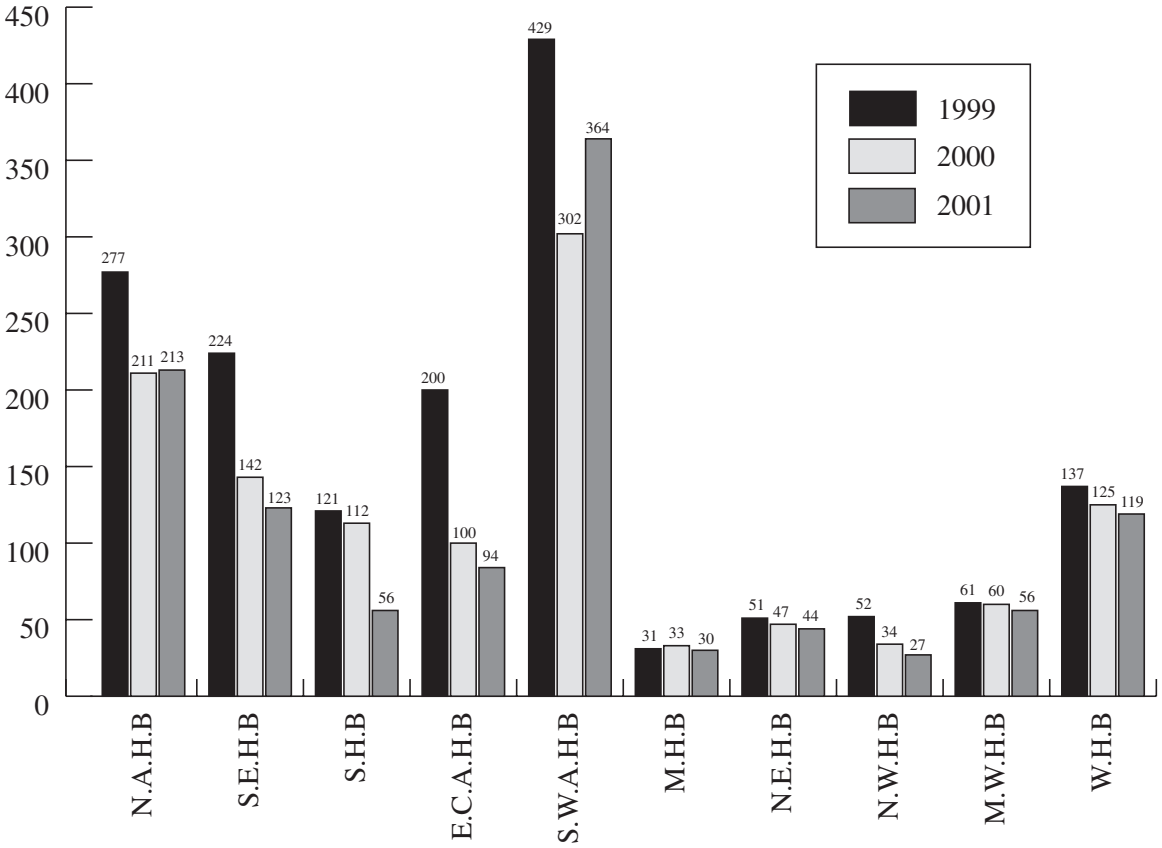
SOUTH WESTERN HEALTH BOARD

Hospital & In-Patient Unit	No. of Episodes of Seclusion	No. of Patients Placed in Seclusion
St. James's Hospital	0	0
St. Loman's Hospital	80	24
Tallaght Hospital	N/A	N/A
Kildare M. H. S. Lakeview Unit	80	16
St. Patrick's Hospital & St. Edmundsbury	0	0
Hampstead Private	0	0
Total	160	40

	No. of Episodes of Seclusion	No. of Patients Placed in Seclusion
Western Health Board	23	1
Southern Health Board	69	99
South Eastern Health Board	952	104
Midland Health Board	47	23
North Western Health Board	46	9
Mid Western Health Board	49	7
North Eastern Health Board	20	9
E.R.H.A.		
Northern Area Health Board	1,367	306
East Coast Area Health Board	891	119
South Western Area Health Board	160	40
Total	3,624	717

INSPECTORATE OF MENTAL HOSPITALS

Regional Variation of Prescription of E.C.T. 1999-2001



¥ No Figures for N.A.H.B — St. Vincent s, Fairview 2000

¥ No Figures for S.H.B. — Bantry Hospital 1999

¥ No Figures for S.W.A.H.B — St. Loman s Hospital 1999

¥ No Figures for E.C.A.H.B — St. John of God 1999

INSPECTORATE OF MENTAL HOSPITALS

PRESCRIPTION OF ELECTRO CONVULSIVE THERAPY — NUMBER OF PATIENTS — 2001

WESTERN HEALTH BOARD

Hospital & In-Patient Unit	E.C.T.
St. Bridget's Hospital Ballinasloe	63
University Hospital, Galway Psych. Unit	33
St. Mary's Hospital, Castlebar	10
Roscommon Mental Health Service	13
Total	119

SOUTHERN HEALTH BOARD

Hospital & In-Patient Unit	E.C.T.
Our Lady's Hospital Cork	16
St. Stephen's Hospital	15
Cork University Hospital Psych. Unit	8
Bantry Psychiatric Unit	0
Tralee General Hospital, Psych. Unit	25
St. Finan's Hospital, Killarney	0
Total	64

SOUTH EASTERN HEALTH BOARD

Hospital & In-Patient Unit	E.C.T.
St. Dympna's Hospital, Carlow	1
St. Canice's, Kilkenny	11
St. Luke's, Clonmel	0
St. Michael's Unit Clonmel	29
St. Otteran's, Waterford	0
Waterford Regional Hospital Psychiatric Unit	60
St. Senan's, Enniscorthy	22
Total	123

MIDLAND HEALTH BOARD

Hospital & In-Patient Unit	E.C.T.
St. Fintan's Hospital	11
St. Loman's Hospital	19
Total	30

NORTH-WESTERN HEALTH BOARD

Hospital & In-Patient Unit	E.C.T.
Sligo Mental Health Services	7
St. Conal's Letterkenny	0
Letterkenny General Hospital Psych. Unit	20
Total	27

MID-WESTERN HEALTH BOARD

Hospital & In-Patient Unit	E.C.T.
Our Lady's Hospital, Ennis	9
St. Joseph's Hospital Limerick	0
Limerick Regional Hospital	47
Total	56

NORTH EASTERN HEALTH BOARD

Hospital & In-Patient Unit	E.C.T.
St. Brigid's Hospital, Ardee	24
Our Lady's Hospital, Navan Psych. Unit	11
St. Davnet's Hospital, Monaghan	1
Cavan General Unit, Psych. Unit	8
Total	44

EASTERN REGIONAL HEALTH AUTHORITY

NORTHERN AREA HEALTH BOARD

Hospital & In-Patient Unit	E.C.T.
St. Brendan's Hospital	142
St. Ita's Hospital	34
St. Joseph's Mental Handicap Services	0
Mater Hospital Psych. Unit	14
St. Vincent's Hospital, Fairview	2
James Connolly Memorial Hospital	21
Total	213

EAST COAST AREA HEALTH BOARD

Hospital & In-Patient Unit	E.C.T.
St. Vincent's Hospital, Elm Park	7
Vergmount, Clonskeagh Psych. Unit	21
Newcastle Hospital, Co. Wicklow	22
Central Mental Hospital, Dundrum	0
St. John of God, Stillorgan & Area 1 Service	34
Total	84

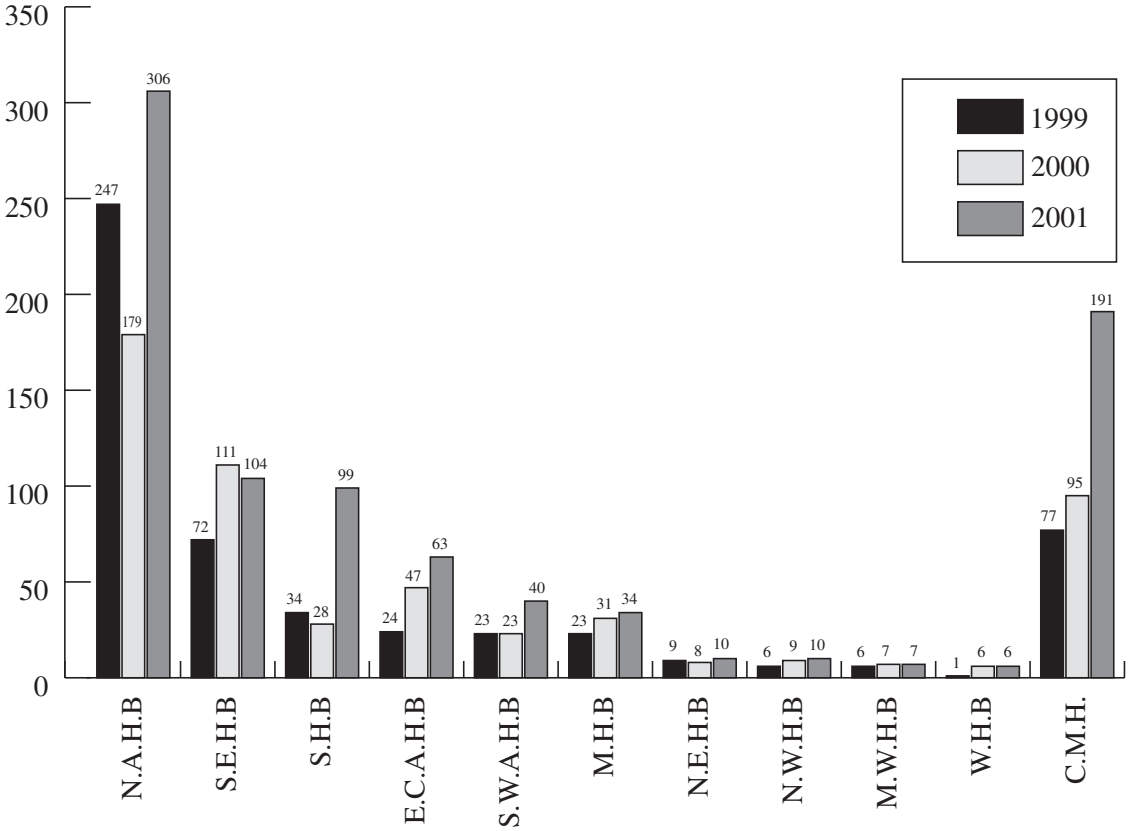
SOUTH WESTERN HEALTH BOARD

Hospital & In-Patient Unit	E.C.T.
St. James's Hospital	10
St. Loman's Hospital	0
Tallaght Hospital	47
Kildare M. H. S. Lakeview Unit	15
St. Patrick's Hospital & St. Edmundsbury	292
Hampstead Private	0
Total	364

Health Board	E.C.T.
Western Health Board	119
Southern Health Board	56
South Eastern Health Board	123
Midland Health Board	30
North Western Health Board	27
Mid Western Health Board	56
North Eastern Health Board	44
E.R.H.A.	
Northern Area	213
East Coast Area	84
South Western Area	364
Total	1,116

INSPECTORATE OF MENTAL HOSPITALS

Patients Placed in Seclusion - Regional Variation 1990-2001



*Information from St. John of God Hospital Not Available for 1999

INSPECTORATE OF MENTAL HOSPITALS

SPECIAL NURSING RECORD 2001

WESTERN HEALTH BOARD

Hospital & In-Patient Unit	Spans of Special Nursing	No. of Patients on Special Nursing
St. Bridget's Hospital Ballinasloe	714	41
University Hospital, Galway Psych. Unit	728	43
St. Mary's Hospital, Castlebar	1,210	28
Roscommon Mental Health Service	149	21
Total	2,801	133

SOUTHERN HEALTH BOARD

Hospital & In-Patient Unit	Spans of Special Nursing	No. of Patients on Special Nursing
Our Lady's Hospital Cork	610	25
St. Stephen's Hospital	577	57
Cork University Hospital Psych. Unit	520	23
Bantry Psychiatric Unit	56	5
Tralee General Hospital, Psych. Unit	N/A	N/A
St. Finan's Hospital, Killarney	Nil	Nil
Total	1,763	110

SOUTH EASTERN HEALTH BOARD

Hospital & In-Patient Unit	Spans of Special Nursing	No. of Patients on Special Nursing
St. Dympna's Hospital, Carlow	72	3
St. Canice's, Kilkenny	365	1
St. Luke's, Clonmel	30	5
St. Michael's Unit Clonmel	170	21
St. Otteran's, Waterford	6	1
Waterford Regional Hospital Psychiatric Unit	9	1
St. Senan's, Enniscorthy	621	6
Total	1,273	38

MIDLAND HEALTH BOARD

Hospital & In-Patient Unit	Spans of Special Nursing	No. of Patients on Special Nursing
St. Fintan's Hospital	372	21
St. Loman's Hospital	386	15
Total	758	36

NORTH-WESTERN HEALTH BOARD

Hospital & In-Patient Unit	Spans of Special Nursing	No. of Patients on Special Nursing
Sligo Mental Health Services	710	31
St. Conal's Letterkenny	0	0
Letterkenny General Hospital Psych. Unit	741	24
Total	1,451	55

MID-WESTERN HEALTH BOARD

Hospital & In-Patient Unit	Spans of Special Nursing	No. of Patients on Special Nursing
Our Lady's Hospital, Ennis	1,840	48
St. Joseph's Hospital Limerick	5,162	86
Limerick Regional Hospital	64	64
Total	7,066	198

NORTH EASTERN HEALTH BOARD

Hospital & In-Patient Unit	Spans of Special Nursing	No. of Patients on Special Nursing
St. Brigid's Hospital, Ardee	258	12
Our Lady's Hospital, Navan Psych. Unit	432	11
St. Davnet's Hospital, Monaghan	2	1
Cavan General Unit, Psych. Unit	132	2
Total	824	26

EASTERN REGIONAL HEALTH AUTHORITY

NORTHERN AREA HEALTH BOARD

Hospital & In-Patient Unit	Spans of Special Nursing	No. of Patients on Special Nursing
St. Brendan's Hospital	414	14
St. Ita's Hospital	52	13
St. Joseph's Mental Handicap Services	359	4
Mater Hospital Psych. Unit	37	4
St. James's Hospital Psych. Unit	8	2
St. Vincent's Hospital, Fairview	N/A	N/A
James Connolly Memorial Hospital	1,073	29
Total	1,943	66

EAST COAST AREA HEALTH BOARD

Hospital & In-Patient Unit	Spans of Special Nursing	No. of Patients on Special Nursing
St. Vincent's Hospital, Elm Park	214	16
Vergmount, Clonskeagh Psych. Unit	388	36
Newcastle Hospital, Co. Wicklow	34	6
Central Mental Hospital, Dundrum	0	0
St. John of God, Stillorgan & Area 1 Service	0	0
Total	636	58

SOUTH WESTERN HEALTH BOARD

Hospital & In-Patient Unit	Spans of Special Nursing	No. of Patients on Special Nursing
St. James's Hospital	28	3
St. Loman's Hospital	846	24
Tallaght Hospital	N/A	N/A
Kildare M. H. S. Lakeview Unit	263	10
St. Patrick's Hospital & St. Edmundsbury	297	6
Hampstead Private	176	3
Total	1,610	46

	Spans of Special Nursing	No. of Patients on Special Nursing
Western Health Board	2,801	133
Southern Health Board	1,243	87
South Eastern Health Board	1,273	38
Midland Health Board	758	36
North Western Health Board	1,451	51
Mid Western Health Board	7,066	198
North Eastern Health Board	824	26
E.R.H.A.		
Northern Area Health Board	1,943	66
East Coast Area Health Board	636	58
South Western Area Health Board	1,610	46
Total	19,605	739

WESTERN HEALTH BOARD

Hospital & In-Patient Unit	No. Temp Admiss	No. Temp Extns	No. Vol Regrad	No. Invol Regrad	No. P.U.M. Admiss
St. Bridget's Hospital Ballinasloe	71	6	20	33	54
University Hospital, Galway Psych. Unit	88	7	0	87	0
St. Mary's Hospital, Castlebar	80	0	24	34	2
Roscommon Mental Health Service	47	0	5	10	3
Total	286	13	49	164	59

SOUTHERN HEALTH BOARD

Hospital & In-Patient Unit	No. Temp Admiss	No. Temp Extns	No. Vol Regrad	No. Invol Regrad	No. P.U.M. Admiss
Our Lady's Hospital Cork	117	14	4	15	0
St. Stephen's Hospital	22	12	8	11	0
Cork University Hospital Psych. Unit	55	0	0	103	0
Bantry Psychiatric Unit	23	0	0	16	0
Tralee General Hospital, Psych. Unit	72	0	0	5	0
St. Finan's Hospital, Killarney	36	16	3	0	0
Total	325	42	15	150	0

SOUTH EASTERN HEALTH BOARD

Hospital & In-Patient Unit	No. Temp Admiss	No. Temp Extns	No. Vol Regrad	No. Invol Regrad	No. P.U.M. Admiss
St. Dympna's Hospital, Carlow	17	0	3	5	1
St. Canice's, Kilkenny	36	12	2	1	0
St. Luke's, Clonmel	23	4	0	0	0
St. Michael's Unit Clonmel	104	1	0	11	0
St. Otteran's, Waterford	57	8	0	N/A	0
Waterford Regional Hospital Psychiatric Unit	6	0	0	0	0
St. Senan's, Enniscorthy	54	3	4	14	2
Total	297	28	9	31	3

MIDLAND HEALTH BOARD

Hospital & In-Patient Unit	No. Temp Admiss	No. Temp Extns	No. Vol Regrad	No. Invol Regrad	No. P.U.M. Admiss
St. Fintan's Hospital	55	1	10	14	0
St. Loman's Hospital	115	14	11	31	0
Total	170	15	21	45	0

NORTH-WESTERN HEALTH BOARD

Hospital & In-Patient Unit	No. Temp Admiss	No. Temp Extns	No. Vol Regrad	No. Invol Regrad	No. P.U.M. Admiss
Sligo Mental Health Services	45	0	16	18	28
St. Conal's Letterkenny	0	0	0	0	0
Letterkenny General Hospital Psych. Unit	93	4	0	15	0
Total	138	4	16	33	28

MID-WESTERN HEALTH BOARD

Hospital & In-Patient Unit	No. Temp Admiss	No. Temp Extns	No. Vol Regrad	No. Invol Regrad	No. P.U.M. Admiss
Our Lady's Hospital, Ennis	39	0	8	7	26
St. Joseph's Hospital Limerick	1	7	N/A	N/A	N/A
Limerick Regional Hospital	102	0	24	2	1
Total	142	7	32	9	27

NORTH EASTERN HEALTH BOARD

Hospital & In-Patient Unit	No. Temp Admiss	No. Temp Extns	No. Vol Regrad	No. Invol Regrad	No. P.U.M. Admiss
St. Brigid's Hospital, Ardee	32	19	14	11	0
Our Lady's Hospital, Navan Psych. Unit	40	0	0	25	0
St. Davnet's Hospital, Monaghan	11	2	6	1	1
Cavan General Unit, Psych. Unit	34	0	7	0	0
Total	117	21	27	37	1

EASTERN REGIONAL HEALTH AUTHORITY

NORTHERN AREA HEALTH BOARD

Hospital & In-Patient Unit	No. Temp Admiss	No. Temp Extns	No. Vol Regrad	No. Invol Regrad	No. P.U.M. Admiss
St. Brendan's Hospital	114	102	16	17	4
St. Ita's Hospital	74	12	15	13	0
St. Joseph's Mental Handicap Services	1	0	0	0	0
Mater Hospital Psych. Unit	24	9	0	5	0
St. Vincent's Hospital, Fairview	140	9	0	0	0
James Connolly Memorial Hospital	17	0	0	0	4
Total	370	132	31	35	8

EAST COAST AREA HEALTH BOARD

Hospital & In-Patient Unit	No. Temp Admiss	No. Temp Extns	No. Vol Regrad	No. Invol Regrad	No. P.U.M. Admiss
St. Vincent's Hospital, Elm Park	6	0	0	1	0
Vergmount, Clonskeagh Psych. Unit	23	0	3	0	0
Newcastle Hospital, Co. Wicklow	53	13	16	6	0
Central Mental Hospital, Dundrum	5	0	0	N/A	0
St. John of God, Stillorgan & Area 1 Service	58	0	N/A	N/A	0
Total	145	13	19	7	0

SOUTH WESTERN HEALTH BOARD

Hospital & In-Patient Unit	No. Temp Admiss	No. Temp Extns	No. Vol Regrad	No. Invol Regrad	No. P.U.M. Admiss
St. James's Hospital	46	0	3	1	0
St. Loman's Hospital	0	0	0	0	0
Tallaght Hospital	84	0	0	4	0
Kildare M. H. S. Lakeview Unit	114	140	0	12	2
St. Patrick's Hospital & St. Edmundsbury	49	0	N/A	N/A	0
Hampstead Private	0	0	0	0	0
Total	293	140	3	17	2

Cumulative Figures	No. Temp Admiss	No. Temp Extns	No. Vol Regrad	No. Invol Regrad	No. P.U.M. Admiss
Western Health Board	286	13	49	164	59
Southern Health Board	325	42	15	150	0
South Eastern Health Board	297	28	9	31	3
Midland Health Board	170	15	21	45	0
North Western Health Board	138	4	16	33	28
Mid Western Health Board	142	7	32	9	27
North Eastern Health Board	117	21	27	37	1
E.R.H.A.					
Northern Area Health Board	370	132	31	35	8
East Coast Area Health Board	145	13	19	7	0
South Western Area Health Board	293	140	3	17	2
Total	2,283	415	222	528	128

N/A = Statistical Information not available from Service Provider.

APPENDIX 2

Procedures Checklist

APPENDIX 2

INSPECTORATE OF MENTAL HOSPITALS
HOSPITAL & SERVICE CHECKLIST

CONSUMER INFORMATION AND TRANSPARENCY

Introduction and Identification

- The patient should be introduced to the professional team responsible for his/her care.
- Patient should know treating consultant and have reasonable access to consultant and members of the multi-disciplinary team.
- Patients should have a right to meet with their treating consultant.
- Staff members should wear identity badges, indicating designation within multidisciplinary team.
- On request all staff should be available for patients and relatives within a reasonable time.
- Staff should identify themselves to the patient as soon as any professional or clinical interaction takes place.

The Treatment Plan

- Patients should be informed of diagnosis and provided with suitable information and literature on their condition in all appropriate circumstances.
- Treatment plans should be discussed with patients.
- Treatment plans, including medication, should be clearly recorded in patients' case notes.
- The nature of treatment and medication should be explained to patients in language they understand.
- Written information should be available to patients on prescribed medication relating to its effects and side effects.
- Patients should be given reasonable time to consider treatment plans and medication, and have the opportunity to discuss treatment plans with relatives if required.
- Patients should be made aware of voluntary self help groups relevant to their illness and how to access them.

Consumer/Complaints

- A written procedure for dealing with complaints from patients and families should be available. Patients should be made aware of its existence and how to use it.
- Patients should be encouraged to make a complaint (verbal or written) to the local service if they feel aggrieved or dissatisfied.
- Notices to this effect should be prominently displayed at every treatment location with the name of the local complaints officer.
- A handbook containing information on complaints procedure and patients' rights to learn about his/her treatment plan and medication should be available for patients' and relatives' information and reference.
- Written procedures for dealing with complaints from patients and relatives should be available in each local service.
- This written procedure on complaints should indicate the level of authority expected to deal with complaints.
- There should be a specific register for the recording of complaints with a designated complaints officer maintaining this record.
- There should be a consistent approach to recording and investigating of complaints.
- There should be written guidelines on complaints alleging abuse and ill treatment of patients.
- These guidelines should be known to staff members and available on request to patients and families.

Protection of the Consumer — Mental Health Legislation

- There should be written information for patients and relatives on their rights under the Mental Treatment Act, 1945 and amending legislation.
- Patients should be cared for in the least restrictive environment possible.
- Patients should be informed of their right of appeal when they are not satisfied with the local complaints procedure.
- Patients should be able to access care and treatment as near as possible to their homes.
- There should be full information on care and treatment available to the patient and if appropriate his/her relatives if the patient agrees.
- Patients should have informed consent and be aware of their rights in relation to refusal of treatment.
- Patients should have access to specialised treatments and spiritual care as appropriate.
- Patients should have a right to change their treating psychiatrist within the catchment area team.

Research

- All patient participation in clinical trials should be in accordance with clinical trials legislation.
- There should be a representative and properly constituted ethics committee which approves all clinical trials.
- Formal written informed consent of the patient should be unequivocally obtained before the participation of the patient in any clinical trial.

The Product/Process/Partners in Care

- There should be a diagnosis and step-by-step treatment and care plan for each patient.
- Treatment plans for patients should be decided at multidisciplinary meetings whether in in-patient or community-based settings.
- Multi-disciplinary team meetings should be informed by a full case presentation involving psychiatric, nursing, psychological and social inputs leading to a diagnosis and definitive action care plan.
- All care planning should be adequately recorded in medical case notes.
- Nurse care planning should evolve on an agreed model of nursing care with specific goals, target dates and review dates.
- The nurse care planning system should commence with a nursing assessment covering all aspects of patient care, physical, psychological and social.
- Care plans should incorporate specific problems such as disturbed behaviour and where appropriate, physical nursing care.
- Risk assessment in areas of pressure sores and infection control should be included in the care plan as appropriate.
- Medical, paramedical and nursing care plans should be clearly documented in the appropriate section of the case file and entries signed in full with date and time.
- Family members should have the opportunity to discuss a patient's care and treatment with the consultant and members of the multidisciplinary team subject to the patient's agreement.
- Family members should have access to advice and information on all aspects of the patient's illness and treatment prognosis and caring arrangements if the patient agrees.
- Subject to the patient's agreement, carers should have a right to all possible information concerning the patient's illness and its treatment and should be put in touch with voluntary and self-help groups when that is deemed appropriate.
- Relatives should be made aware of their right to complain and their rights of external appeal under current mental health legislation.

The Right to Privacy

- Interviews between patients and relatives and mental health staff should be effected in settings which provide privacy.

THE PROCESS

Admission to In-patient Care

- A fully documented admission policy and procedure document should be available in each service.
- Admission decisions should generally be made by consultant psychiatrists.
- Decisions to admit patients involuntarily should be the exclusive right of consultant psychiatrists and they alone should complete temporary patient reception orders.
- The physical surroundings in the admission/reception area for patients should be reassuring, comfortable and private.
- Patients indicating a willingness to remain in hospital and giving no indication of wanting to leave should be asked to enter hospital as a voluntary patient.
- All necessary information relating to a patient's stay in hospital, their rights under the Mental Treatment Act, 1945 and amending legislation, should be transmitted to the patient and to their relatives, where appropriate, at the time of admission.

Clinical Review

- Involuntary patients should have their status changed to voluntary as soon as it is deemed appropriate.
- All newly admitted patients should be clinically reviewed on a daily basis and the results of such review documented clearly in the case notes.
- All entries by professional staff in clinical documentation should be signed legibly and in full with the designation of the professional staff member stated.
- There should be a written policy on the care of patients' case notes.
- Administrative and biographical details (name, address, date of birth etc.) should be completed in full for each admission.
- A section of this form should contain information relating to discharge date, final diagnosis on discharge and this should be completed in full.
- Individual patient case records should contain information on the following:—
    - History of the illness for which the patient is being treated, personal history of the patient, patient's family history.
    - Diagnosis, legal status of the patient.
    - Particulars of medical examination on reception and all reviews, changes in the mental condition of the patient, any unusual occurrences, absence on leave/parole/pass.
    - Date of discharge, assessment prior to discharge and in the case of death, the cause of death.
- Correspondence and investigation reports should be correctly filed in chronological order and copies of previous discharge summaries should be readily available in case notes.
- All professional progress notes (e.g. social worker, psychologist, occupational therapist) should be completed by such staff and readily accessible in patients' care records.

Medical Preparations

- There should be a written policy for the ordering, prescribing, storing and administering of medicines.
- The medical preparations policy should be signed, dated with an appropriate review date and available in each clinical area for information and reference.
- The medical preparations policy and procedure should contain information on staff responsibility relating to ordering drugs, storage and checking drug stocks, administering drugs, mode of administration and information on drugs given to patients on discharge.

- There should be written instructions for the use of prescription cards with one signature and one date for each prescription.
- The discontinuation column of the prescription card should have one signature and one date for each prescription.
- The drug administration recording card should have provision for a nurse's signature in full.
- There should be written guidelines for the use of (PRN) medications. Medication prescribed to be given whenever necessary rather than at fixed times.

Electro Convulsive Therapy (ECT)

- This procedure should only be administered to patients with their fully informed written consent.
- There should be a written protocol for the administration of ECT.
- Guidelines for the administration of ECT should be displayed prominently in the treatment room including a pre and post ECT nursing check list.
- A named consultant psychiatrist should be responsible for the ECT programme and oversee its administration.
- There should be a specific ECT treatment record form incorporating the consent form.
- The treatment facilities for ECT should incorporate waiting, treatment and recovery rooms.
- Adequate monitoring and resuscitation equipment should be available in each treatment unit.
- The administration and clinical response to ECT should be documented clearly in patients' case notes.
- All staff working in the service should have regular cardio-pulmonary resuscitation and foreign body airway obstruction training.

Primary Nursing in the Hospital Setting

- Each patient should be allocated a nurse directly responsible for the patient's care at ward level on a day to day basis.
- The nurse in charge should determine the number of patients for whom each primary nurse should have direct responsibility.
- The assigned primary nurse should have responsibility for nursing care plan documentation and for the presentation of clinical aspects of the patient's condition at multi-disciplinary review meetings.

Seclusion and Restraint

- Where seclusion occurs there should be a clear written seclusion policy including the definition of seclusion with relevant extracts from the Mental Treatment Act, 1945 and amending legislation.
- A separate nursing seclusion care plan for the patient should be introduced once a patient is placed in seclusion.
- Seclusion should only be prescribed in writing by a consultant psychiatrist and should be reviewed on a six hourly basis.
- In the rare instances mechanical restraint is used, the same procedures should apply.
- A seclusion register should be maintained and the fifteen minute nursing observation should be fully documented.

Persons detained under Reception Orders

- The patient must be involved in the decision relating to absence on trial and must consent to any consultation with relatives relating thereto.
- Decisions relating to absence on parole/pass rest with the consultant psychiatrist and should be appropriately recorded in the patient's case file.

Discharge

- Before discharge, the service should ensure the patient's housing conditions are satisfactory and that the patient's family is aware of the patient's pending discharge.

- Following discharge, a discharge summary should be sent to the general practitioner or other components of the psychiatric service responsible for follow-up.
- The discharge summary should set out the principal details of the patient's management and treatment while in hospital including medication on discharge.
- The discharge summary should detail follow-up plans including the role of the general practitioner and give details of diagnosis, treatment and medication in hospital and the results of any tests or investigations carried out.
- Patients on discharge should be supplied with a standard form giving them information on drugs prescribed for them.
- The name of their general practitioner should be supplied to the patient.
- The telephone number of the mental health centre where staff can be contacted and a domiciliary visit or other arrangements made in the case of emergencies should be supplied to the patient.

THE SETTING

Hospital and Unit

- Residential premises should be clean, neat, well maintained and where appropriate provide a variety of day time activities.
- In-patient units should provide:—
  - appropriate levels of safety and security for patients and staff;
  - private bathing facilities;
  - single gender toilet facilities;
  - access to smoking and non-smoking areas;
  - access to private outdoor space;
  - access to public telephone;
  - easy access to public transport, churches and shopping facilities;
  - adequate facilities for the physically disabled;
  - facilities for leisure activities;
  - adequate facilities for visitors;
- All units should be comfortable, maintained in good decorative order and appropriately furnished.
- Grounds adjoining the units and the buildings should be maintained in good condition.
- There should be adequate internal and external signposting.
- All residential in-patient units should be provided with a calendar, clock and wall thermometer.

Catering

- The quality of food for patients should be satisfactory and patients should have reasonable choice.
- There should be a written printed menu reviewed periodically and on display for patients' information.
- The physical environment of dining areas and the quality of tableware should be satisfactory.
- Meals should be provided at socially acceptable times.
- Catering and ancillary staff should be provided with appropriate training.

Maintenance

- There should be easy and ready access to maintenance services which should be supplied promptly and adequately.
- Grounds and gardens should be maintained to a proper standard and sufficient staff should be available to ensure that this is the case.

- All toilet and bathing facilities should be kept clean with the provision of soap, towels and other toilet requisites on a personalised basis individual to each patient.

Privacy and Dignity

- All clothing should be personal to the patient and patients should have adequate storage space for clothing and belongings.
- There should be adequate equipment to wash and dry personal clothing.
- Sleeping accommodation should be adequate in floor area, uncluttered and uncrowded.
- Patients should have rails and curtains for each bed in the multi-bed areas of in-patient units to ensure privacy.
- Visiting times should be prominently displayed and these should be reasonably generous.
- Relatives should have visiting rights outside the normal visiting times where circumstances prevent them from visiting during designated times.
- Patients should never be deprived of appropriate day time clothing with the intention of restricting their freedom of movement unless it is part of a treatment plan determined by a consultant psychiatrist.

Safety Procedures

- The hospital and local units should have a written safety statement.
- There should be a safety committee with an identifiable safety officer.
- Written records of safety committee meetings should be kept.
- Hazard control sheets indicating periodic safety audits and follow-up should be kept in each local area.

Fire Precautions

- Each service should have a fire committee which meets periodically.
- Records of fire committee meetings should be kept.
- Incidents concerning a fire outbreak should be recorded together with action taken by staff in the particular circumstances.
- All staff should have ongoing training courses in fire precaution techniques and evacuation procedures.
- There should be regular checking and inspections of equipment, safety exits and fire escapes.
- Fire orders should be prominently displayed and fire exits clearly marked.
- Residential premises external to the hospital in-patient setting should be provided with a telephone and residents should be aware of telephone numbers to contact in case of emergency.

Out-patient Facilities and Mental Health Centres

- Out-patient clinics, day hospitals and day centres should be suitably located for easy access.
- An appointment system, known to referral agents, ensuring patients have a minimal wait for attendance should be in operation in all community facilities.
- The appointment system should ensure adequate time for consultation with professional staff.
- Mental health centres should form the operational base of mental health teams.
- Mental health centres should allow close co-ordination and integration with primary health care teams.
- Such facilities should include secretarial assistance to ensure letters are issued within the minimum time possible following consultation.
- Adequate documentation in terms of case records and treatment plans should be maintained and safely stored.

Community Residences

- Community residences should be good quality, comfortable, well designed with furnishings and decor to meet the needs of residents.

- Residents should have involvement in choosing or planning changes to furniture and decor in their residence as appropriate.
- There should be a system which monitors the implementation of community residence operational policies and procedures.
- Catering should be efficient with meals varied, well presented and flexibly provided.
- Residents should be encouraged to help with the preparation of food, cooking and cleaning up.
- Patient residential accommodation should not be institutional in appearance.
- There should be reasonable access to public transport and community facilities.
- Residences should be satisfactorily decorated and maintained with adequate security provided to protect property and residents.
- Residences should contain telephones and residents should know who to contact in emergency and contact telephone numbers should be readily available.
- All community residences should be protected by an automatic fire detection system.
- Fire exits should be clearly marked and written fire orders prominently displayed.
- Written records should be kept of fire drills and evacuation exercises.
- Residences should be visited and inspected periodically by the fire prevention officer, health and safety officer, fire equipment service personnel and senior nursing personnel.
- Residents should be encouraged to take charge of their own financial affairs.
- Residents should play an active part in the furnishing and decoration of their homes.
- The weekly scale of charges to residents should be specified and these should be reviewed and revised periodically.
- Arrangements for residents unable to look after their day to day finances should be satisfactory and subject to regular checking.

PERSONAL SAFETY FOR STAFF

Training

- All staff should be trained in the techniques of management of violence and aggression through participation in a recognised training course.
- Training courses relating to management of violence and aggression should be organised on an ongoing basis so all staff have the opportunity to attend refresher courses periodically.
- All staff should be trained in the manual handling of loads and safe lifting techniques.
- If considered appropriate staff should carry personal safety alarms.

GENERAL ADMINISTRATIVE ARRANGEMENTS

Administrative Arrangements

- There should be a document outlining the philosophy and model of care delivery for the service as a whole, and the document should be available in each component of the service and available and understood by every staff member.
- There should be a written local mental health programme adapted to meet the objectives and targets that are enshrined and understood in the philosophy and model of care.
- There should be a written strategy identified and understood by which these targets and objectives may be met.
- There should be mechanisms in place to ensure that through the strategy the programme and its aims are working towards the final targets.
- Mechanisms, such as a service management group, sector groups and so on should be in place to ensure that the strategies, programmes etc. can be applied and realistic targets achieved.

- There should be a clear understanding between service deliverers and policy makers on the budget available so that targets which are feasible and possible, may be achieved.
- At the unit/ward level, day centre/day hospital level or mental health sector headquarters there should be an operational policy which records the agreed information about how that particular component of the organisation operates.
- This policy should be available in written form so that it can be read and understood by all staff members and if necessary by patients and visitors.
- There should be an annual review of the quality, efficiency, and effectiveness of all aspects of the mental health service.
- The review should identify strengths and weaknesses in policy programmes with a view to modifying and improving them.
- These programme goals should be written down and anchored to local objectives.
- A written report of the annual review should be kept.
- Service objectives should be discussed, understood and approved by health board members.
- There should be a good working relationship between health board members, senior executives and service providers.

APPENDIX 3

Procedures for Transfers under Section 208

APPENDIX 3

SECTION 208 OF THE MENTAL TREATMENT ACT, 1945
PROCEDURES FOR THE TRANSFER, EXTENSION OF TRANSFER AND DISCHARGE OF PATIENTS

1. PROCEDURES FOR TRANSFER

1.1 A health board or a Clinical Director acting on its behalf or the authority of a registered psychiatric hospital may seek the transfer of a detained patient in need of specialist treatment under Section 208 of the Mental Treatment Act 1945 to the Central Mental Hospital, Dundrum, subject to the following conditions:

(i) that an application for admission is completed on the prescribed form (copy attached);

(ii) that the patient has been assessed by his/her Consultant Psychiatrist as being in need of specialist treatment which is not available locally and which in the opinion of the Consultant Psychiatrist can more appropriately be provided in the Central Mental Hospital;

(iii) that the patient has been assessed by the person in charge (Clinical Director/ RMS/Chief Psychiatrist) as being in need of specialist treatment which is not available locally and which in the opinion of the person in charge can more appropriately be provided in the Central Mental Hospital. If the patient is under the clinical care of the person in charge, he or she should arrange for a second opinion by another consultant psychiatrist;

(iv) that the patient has been assessed by the Clinical Director of the Central Mental Hospital as in need of specialist treatment which is not available locally and which in his/her opinion can more appropriately be provided in the Central Mental Hospital;

(v) that the patient and the patient's next-of-kin have been informed by the Consultant Psychiatrist of the referring hospital of the proposed transfer at least 24 hours before the transfer takes place and of their rights under the Mental Treatment Act and their right to have their case investigated by the Inspectorate of Mental Hospitals. As far as is practicable the wishes of the patient and the patient's next-of-kin should be accommodated;

(vi) that the Inspectorate of Mental Hospitals has been informed of the proposed transfer;

(vii) when all of these steps have been completed, the patient may be transferred to the Central Mental Hospital within a period of four days; it is a matter for the health board or hospital authority applying for the admission to arrange transport to the Central Mental Hospital;

(viii) following the admission of the patient to the Central Mental Hospital, a copy of the completed application form should be forwarded to the Inspectorate of Mental Hospitals by the Clinical Director of the Central Mental Hospital.

2. LENGTH OF TRANSFER FOR TREATMENT

2.1 A patient may only be treated in the Central Mental Hospital under Section 208 of the Mental Treatment Act if he or she is legally detained in his or her parent hospital. **It will be the responsibility of the Clinical Director of the referring service to ensure that the legal requirements in relation to the detention of a patient referred to Dundrum for specialist treatment are met.**

2.2 The initial length of the transfer for treatment in the Central Mental Hospital will be 28 days. It will be a matter for the Clinical Director of the Central Mental Hospital to decide whether the patient requires an extension of a period of treatment at the Central Mental Hospital. A period of treatment of 28 days there may be extended to three months, which may be renewed for further periods of three months. The Clinical Director of the Central Mental Hospital will notify the Inspectorate of Mental Hospitals and the referring Clinical Director/RMS/Chief Psychiatrist of each extension of a period of treatment. It is the responsibility of the latter to ensure that the legal requirements in relation to the detention of the patient are met.

2.3 On the completion of each period of treatment under Section 208 (i.e. initial 28 days followed by each three month extension), a further treatment plan will be prepared and forwarded to the Inspectorate of Mental Hospitals.

2.4 A summary of all treatment plans prepared by the Central Mental Hospital shall be forwarded to the patient's referring consultant who will in turn inform the patient's General Practitioner.

3. DISCHARGE FROM CENTRAL MENTAL HOSPITAL

3.1 If the Clinical Director of the Central Mental Hospital decides that a patient no longer requires the specialist treatment available in the Central Mental Hospital, no clinical basis will exist for the patient's continued stay in the Central Mental Hospital and he or she will be transferred back to his/her referring hospital.

(i) The Clinical Director of the Central Mental Hospital shall inform in writing the Clinical Director/R.M.S./Chief Psychiatrist of the referring hospital of the proposal to transfer back the patient to his/her referring hospital. A copy of this letter shall be forwarded to the Inspectorate of Mental Hospitals for his information.

(ii) A copy of all treatment plans prepared by the Central Mental Hospital shall be forwarded to the Clinical Director/R.M.S./Chief Psychiatrist of the referring hospital.

(iii) The Clinical Director/R.M.S./Chief Psychiatrist will be responsible for ensuring that the legal requirements in relation to the continued detention of the patient are met.

(iv) When all of these steps have been completed, the patient may be transferred back to the parent hospital within a period of seven days; it is a matter for the health board or hospital authority of the referring hospital to arrange for transport.

(v) The patient shall be informed by the Clinical Director of the Central Mental Hospital and the patient's next of kin shall be informed by the Consultant Psychiatrist of the referring hospital of the proposed transfer at least 24 hours before the transfer takes place.

TRANSFER OF PATIENT UNDER SECTION 208,
MENTAL TREATMENT ACT, 1945

Application from _____ Clinical Director/R.M.S./Chief Psychiatrist acting on behalf of _____ Health Board or the authority of a registered psychiatric hospital to the Clinical Director of the Central Mental Hospital to admit a patient under Section 208, Mental Treatment Act, 1945 to the Central Mental Hospital.

1. Particulars of patient:—

   Name _____

   Gender _____ Date of Birth _____

   Home Address _____

   _____

   Referring Hospital _____

   Referring Consultant Psychiatrist _____

   Legal Status under Mental Treatment Act 1945 _____

   Next of kin:—

   Name _____

   Address _____

   _____

   Telephone _____

2. Recommendation of **Consultant Psychiatrist**

   I have assessed _____ (patient's name), a patient under my charge, as being in need of specialist psychiatric treatment which is not available locally and which in my opinion can more appropriately be provided in the Central Mental Hospital.

   Signature: _____ Date: _____

3. Recommendation of **Clinical Director/RMS/Chief Psychiatrist**

   I have assessed _____ (patient's name) who is a patient of Dr. _____ (name of consultant in charge of patient) as being in need of specialist psychiatric treatment which is not available locally and which in my opinion can more appropriately be provided in the Central Mental Hospital.

   I also certify that I have examined the original reception order which is kept at _____ (hospital) details of which are as follows:—

   Date of original reception order _____ number of extensions _____

   Expiry date of current reception/temporary order _____

   Signature: _____ Date: _____

4. Recommendation of **Clinical Director of the Central Mental Hospital**

   I have assessed _____ (patient's name) as being in need of specialist psychiatric treatment now which is not available locally and which in my opinion can more appropriately be provided in the Central Mental Hospital.

   Signature: _____ Date: _____

5. **Information to Next-of-Kin**

On _____ (date) I, being Consultant Psychiatrist to _____ (patient's name) informed the patient's next-of-kin, _____(name) of the proposed transfer and of their rights under the Mental Treatment Act, 1945.

Signature: _____ Date: _____

6. Actual date of transfer to the Central Mental Hospital _____

A copy of this completed application form should be sent to the Inspectorate of Mental Hospitals, Department of Health and Children, Hawkins House, Dublin 2.

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