

# Mental Health Commission Coimisiún Meabhair-Shláinte

ANNUAL REPORT | TUARASCÁIL BHLIANTÚIL

including the Report of the Inspector  
of Mental Health Services 2005



2005

*Book Three (of Six)*

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## Chapter 1

Health Service Executive  
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Laois/Offaly, Longford and Westmeath

## MIDLAND REGIONAL HOSPITAL, PORTLAOISE

### DEPARTMENT OF PSYCHIATRY

*Date of inspection:* 7th June 2005

*Number of beds:* 50 beds. 26 male, 18 female, 6 beds for POLL

#### DESCRIPTION

This is an acute unit for general adult and Psychiatry of Later Life (POLL).

#### REFERRAL

Patients are usually referred by either the GP, the sector medical team, a member of the sector multidisciplinary team following discussion with the sector medical team, the Midland Regional Hospitals at Portlaoise and Tullamore following discussion with the sector medical team or by a consultant from another hospital. Occasionally patients may self-refer. A patient who self-refers is assessed by the sector NCHD or the NCHD on call and their management is discussed with the sector consultant or consultant on call. There is a detailed referral and admission policy that outlines the procedure for referral both during normal working hours and out of hours.

#### PROCESS OF ADMISSION

Key admission criteria are identified in the admission policy which, in addition, specifies steps to be taken for involuntary detention. Individuals referred to the Department of Psychiatry for an uncomplicated alcohol detoxification programme are not admitted. Persons with substance misuse problems are not admitted but are referred to the community services. If there is co-morbid psychiatric illness, such persons may require admission to the unit once deemed medically fit by the referring agency.

A record of all assessments made is kept in the admission unit. The referrer is notified immediately if the patient is not admitted.

Adolescents up to the age of 16 years are referred to the Child and Adolescent Mental Health Service. There has been a recent overnight admission of a 16-year-old in crisis. Community Care Services provide services for persons with intellectual disability. Patients are reviewed by the consultant within 24 hours of admission.

#### CARE PLAN

There is no formal multidisciplinary care planning process for in-patients. At the team meetings patients are referred using a specified referral form to the sector occupational therapist, psychologist and/or social worker as deemed appropriate. The occupational therapist, psychologist and social worker do not routinely attend review meetings for in-patients although they do so for outpatients. The Tullamore sector has initiated multidisciplinary care planning for its outpatients. Families and care givers regularly attend the weekly team meetings and are involved in the discharge planning.

#### NURSING PROCESS

The nursing model used is described as an integrated care plan and is an adaptation of the Orem and Roper models. This care plan is completed by the key nurse, who is assigned on a sector basis. It involves collaboration with the patient who completes a section of it. There are set review dates. There is a policy on observation: the observation levels are general, high observation, and special nursing. All nursing staff wear name badges and there is a dress code.

#### ACCESS TO THERAPY AND TREATMENT

Each sector team has a social worker, occupational therapist and psychologist. Access is by referral only. There is currently no psychologist on the POLL team although the team can access psychologist input from the sector team.

Addiction counsellors visit the unit for assessments. The sector team cognitive therapists come to the unit. There is regular consultant psychiatrist review. There is excellent medical and surgical back-up if

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required and many of the other services from the general hospital will come to the ward. Phlebotomy is performed by the NCHDs or by nursing staff who are appropriately trained.

#### ECT

ECT is provided on the unit in a designated suite that includes a waiting area, dressing room, treatment room and a recovery room. There is a designated ECT consultant psychiatrist. Patients receiving ECT are usually accompanied by their key nurse.

#### ACCESS TO ACTIVITIES

There is an activation programme conducted by two nursing staff from 0900h to 1700h five days a week. The programme is drawn up each week and includes management of stress, anxiety and money. Many of the patients attend the programme. The occupational therapist runs a group twice a week and undertakes assessments as required. In addition there is access to the local advocacy service, GROW, yoga, art therapy and literacy services as required. There is a hairdresser available on a regular basis.

#### CLINICAL RISK MANAGEMENT

The nursing care plan does not contain a formal risk assessment although it enquires about any history of violence and risk to others and establishing a safe environment. There is a Healthcare Risk Management Policy available on the unit, which is part of the Corporate Safety Statement. All near misses and untoward incidents are reported on incident report forms and health risk management forms, which are investigated and managed by the health care risk management office.

Seclusion is used in this unit and there are policies and checklists in relation to that. Refractory clothing is never used. The seclusion register documented the date and time of initiation of seclusion and the reason for seclusion. CCTV is used in this ward for monitoring the entrances and reception area and seclusion rooms. There is a pinpoint alarm system with alarms for staff and official visitors. There are policies on alcohol and illegal drugs, conducting

searches, the management of violent incidents, administering injections against resistance, and absconding. Staff are regularly trained and updated in managing violent episodes. There is also regular training in cardio-pulmonary resuscitation. There are two defibrillators on the unit and immediate access to the CRASH team when required.

#### UNIT MANAGEMENT

Since the unit opened there has been no shortage of beds, which means that patients have not been moved out to create vacancies. When patients have been transferred from St. Fintan's Hospital they have been documented as discharges and admissions rather than transfers. This has the effect of raising the admission rate in the catchment area. There are plans to develop a 4-bed step down unit as part of the rehabilitation service, which means that patients not able to be discharged home may be moved on when ready.

The unit is open. If it needs to be locked for any reason the Director of Nursing must be informed in writing. However, both the male and female admissions may be locked off from time to time and this is not documented. Patients usually inform staff if they wish to leave the ward. A central rostering system is in place with a CNM3 on duty day and night. In addition there is a CNM2 and four staff nurses on both the male and female sides during the day and three nurses on the male side at night and two nurses on the female side at night. There is a CNM2 and one staff nurse on duty during the day in the POLL and one nurse at night.

As part of the pilot programme, there is also a care assistant assigned to the male, female, POLL and activation units. There are two porters working in the unit and a number of household staff. There is a receptionist who also functions as a ward clerk. The staff are very satisfied with their access to all the hospital services including maintenance and switchboard. There are set visiting times although these are flexible.

Meal times are at 0830h, 1300h and 1700h.

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### SERVICE USER INVOLVEMENT

There are lots of information boards, leaflets and notices available. There are forms for opinions, comments and complaints available throughout the unit along with suggestion boxes, which are monitored by the senior nursing staff. There are no formal community meetings with patients although staff report that they have regular informal discussions about the service with patients. There are plans to conduct a formal survey of patients and their families regarding their view of the new unit and the service provided. The advocacy service visits the unit each week. There is a formal complaints policy.

### RECORDS

The new patients' charts contain separate entry sheets for medical, nursing, psychology, occupational therapy and social work professionals. The cover of the chart has a printed label for the patient's name and documents the date of birth and any drug sensitivity, but does not have an allergy alert space.

Inside the cover is an administration sheet, which details the patient's biographical details and relevant contact names, addresses and phone numbers. It also gives the patient's status under the Mental Treatment Act. A nursing assessment sheet is included, as is a nursing care plan, which is problem or need focussed and is drawn up in conjunction with the patient. Regular evaluations of this care plan are also documented. Only one of the charts inspected contained an entry from occupational therapy. None contained entries from a psychologist or social worker or contained evidence of multidisciplinary discussion of the patient's case or of multidisciplinary team care planning. The charts contained admission assessments, including physical assessments, by a doctor. A working diagnosis and treatment plan and progress reports were documented. The referral source was identified. All entries were signed and dated but, in many instances, the name of the professional making the entry was not always legible nor was the title used. There was evidence of patients being seen by a consultant within 24 hours of admission and by a NCHD several times per week. A card index system is used for documenting medication. This comprises separate prescription and administration sheets. The generic name of the drug

was not always used. Prescriptions were dated and signed but, on a number of occasions, discontinuation of medication was not signed by the doctor. At present, there is no signature bank in use, but the nursing officer interviewed intimated that one would be put in place shortly.

### ENVIRONMENT

The Department of Psychiatry is a separate unit within the Midland Regional Hospital, Portlaoise. Access is through the main reception of the hospital but the unit has its own reception area, where the receptionist/ward clerk is stationed. This area was bright and clean and had comfortable seating and access to a toilet. A large array of useful information leaflets were contained in leaflet pockets on the wall. Off the reception area is a large assessment room. The door from the hospital to this unit was open during the daytime. A separate entrance to the rear of the unit could be used by ambulance personnel when escorting a patient to the unit. CCTV cameras were used to monitor the main corridors, the two entrances to the unit and the seclusion rooms. The monitor was located in the nursing station. The unit itself was very spacious with a large number of offices, assessment rooms and storage areas. There were dedicated medication stores and clinical rooms and a file records room. Two parallel corridors lead to the residential area of the unit, which was subdivided into male and female sleeping areas and a separate 6-bed unit for the POLL service. The doors to the residential areas could be locked at the discretion of nursing staff. There were three nursing stations on the unit, in the male, female and later life areas respectively. The majority of patients in the unit could access a large, enclosed courtyard, which had adequate seating and was well planted with shrubs and flowers. Patients in the seclusion rooms and the observation area could be accompanied by nursing staff to a smaller courtyard but this had the disadvantage of being overlooked from the main hospital building.

The accommodation on the unit included single, 4-bed and 6-bed rooms and a mother and baby unit. All bedrooms had en-suite toilet, shower and sink facilities. The larger bedrooms had curtains around each bed. All patients had their own wardrobe and cupboards and these could be locked. The bedrooms

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had windows with tinted glass to afford a greater degree of privacy. The doors to the bedrooms all had large glass panels and, as the single rooms had no curtains around the bed, patients had to change in the en-suite to ensure privacy. All bedrooms had call buttons over the beds. There was an adequate number of bathrooms and assisted bathrooms. All rooms, including toilets and bathrooms, were wheelchair accessible. The dining room was spacious and bright with sufficient seating for all. The only dedicated quiet room was on the female side of the unit. There was an adequate number of common rooms, TV rooms and visitors' rooms.

The activity rooms, which could be used by all the patients, comprised a small sitting room with comfortable seating and a homely atmosphere and a larger room, which was used for arts and crafts and various groups. The nursing stations were large and easily accessible. There was sufficient office space, a reading room and a room that was used by students. PCs that had access to library facilities were provided. There was a staff changing room with toilet, shower and individual lockers. There was also a kitchenette for staff. There was an ECT suite on the unit. The waiting area was an alcove off the corridor, which had access to toilets and changing rooms. There was also a treatment room and a recovery room. Both were of adequate size and décor. The ECT machine was a Spectrum 5000M.

## ST. FINTAN'S HOSPITAL, PORTLAOISE

### MALE WARD 6

*Date of inspection:* 8th June 2005

*Number of beds:* 10

#### DESCRIPTION

The ward is described as a long-stay elderly care ward for men. The ward is locked for safety reasons. It has recently become the responsibility of a consultant psychiatrist with a special interest in rehabilitation.

#### REFERRAL

This is not applicable for this ward. There are no admissions and it is described as a long-stay elderly care ward.

#### PROCESS OF ADMISSION

There are no admissions.

#### CARE PLAN

It was reported that a psychosocial model was in use, concentrating on hygiene and personal care. Nursing assessments are carried out and involvement with the patient is encouraged where possible. There is no identified key worker system and care plans do not appear to be reviewed on a regular basis. The ward encourages contact with family members. Some of the patients go home on weekend leave and have trips out with family members.

#### NURSING PROCESS

A psychosocial intervention model that concentrates on physical needs is used. There is little emphasis on mental health problems within this model. There are no risk assessments and no key worker system. One of the files reviewed contained certain risk issues regarding the patient. The nurse in charge was informed that a care plan and risk assessment must be identified to meet the needs of this person's potential risk. The Director of Nursing was also informed. All patients are on general observation. The staff all wear uniform and have identification badges.

#### ACCESS TO THERAPY

The only clinical input to the ward is from doctors and nurses. If it was identified that there was a need for psychology, occupational therapy or social work input the patient is referred and specific pieces of work are implemented. An example was given where there are four fully dependent patients on the ward and they had seating assessments carried out by

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occupational therapy and appropriate chairs were purchased to meet their needs.

There is now a dedicated psychiatrist for this ward, and the NCHD visits daily. There are plans to have monthly reviews of each of the patients. The NCHD monitors patients' physical condition. Patients are transferred to A&E if these needs cannot be met by the NCHD. Six-monthly physical checks are carried out on each of the patients and they have thorough investigations, blood tests and X-rays at the county hospital.

There are three qualified nurses on duty during the day and two at night. The ward also has access to a chiropodist, hairdresser, and the voluntary sector, and also accesses an advocate on occasions.

#### ACCESS TO THERAPEUTIC PROGRAMMES

There is a daily programme in evidence that has a large emphasis on maintaining physical well-being but there are also some groups available. They include discussion groups, music, relaxation and reminiscence.

#### CLINICAL RISK MANAGEMENT

There is a policy in evidence on manual handling but nothing on the potential risks that the patients may pose or their own vulnerability. There is an alarm system in operation that covers both wards in the hospital and there is a response arrangement between the two wards. It was stated there was very little aggression on this ward and that the staff on Ward 6 usually responded to the rehabilitation ward. There is a policy on patients missing from the ward.

Forms of mechanical restraint are in operation on the ward. A number of the dependent patients are strapped into a chair. This is recorded in the patients' notes by the consultant, but there is no policy in place to oversee this practice. It was stated that there is a draft policy in the process of being implemented.

There is a programme of training from the nurse education department in Tullamore. All staff have recently been trained and updated in cardio-pulmonary resuscitation and there is a range of training available to the staff. This ward is also a

student nurse placement and the staff take the preceptor course. The training programme available to the nursing staff does not include training on assessment of risk.

There is a system in place for reporting serious clinical incidents. The forms are sent to the risk management team. They write back to the ward acknowledging receipt of the form and the form is filed in the hazards folder on the ward. The risk management team then review the recommendations made from the form. The risk management team also audit the incident forms. This is a positive example of attempting to manage clinical risk.

#### UNIT MANAGEMENT

There are no transfers, temporary or permanent, from this ward unless a patient's physical needs dictate this. There is a group programme available and this is run on a daily basis within the ward. Each patient has what is called a "parole" system for escorted leave out of the ward (this term promotes a custodial element to the ward and perhaps should be changed to "leave" status). The ward is locked for safety reasons due to the wandering nature of some of the patients.

Regular staff are on duty most of the time, though there is central rostering system in place. There are three nurses on duty during the day and two at night. There are two household staff working on this ward.

New staff are orientated to the ward by an orientation process and also from peer support by other colleagues. It was stated that there is a process in place for ensuring the staff are inducted to the ward. All staff wear a uniform. There is no ward clerk available to this ward. The NCHD takes blood when required.

Although the ward is in a reasonable state of repair it is a low priority on the maintenance programme due to St. Fintan's expected closure. There is no direct dialling externally from the ward. All calls have to go through switchboard.

There are specific times for visiting but the ward is flexible in meeting the needs of the relatives. The patients can have drinks and snacks throughout the

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day and the meals are at set times. Four fully dependent patients are fed on the ward and two other patients stay on the ward. The other four go to a dining room.

#### SERVICE USER INVOLVEMENT

There is no information available on treatment or therapies for the patients on this ward. All patients are voluntary but there is no information on their rights or leaflets about the ward. There is a complaints policy in place on the ward and all complaints go to the Clinical Director, but there are no leaflets to explain this policy. The ward staff obtain the views of carers or family members when they visit. There are no community meetings but there is access to advocacy.

#### RECORDS

Generally the records were very tatty. The covers were torn and there were a number of loose pages in each of the sets of notes reviewed. The patient's name was stated in each of their files and they were legible. All entries were signed and dated. The written notes were by nursing staff and medical staff. There was no evidence of progress reports from allied health professionals, although they are not regularly involved with this patient group. There were various correspondences from the general hospital.

Each of the files contained very old nursing care plans which are in need of review. There is a daily intervention written by the nursing staff. There is evidence of regular reviews by the medical staff. The NCHD visits the ward daily and writes in the notes accordingly. The nursing file is incorporated with the medical file.

#### ENVIRONMENT

This was a long-stay elderly care ward situated in a psychiatric hospital. There were ten male patients residing in this ward. It was unfortunate that it was a low priority on the maintenance programme due to the intended closure of the hospital. Some of the décor needed attention but it was generally in a reasonable state of repair. The bedroom areas were

two connecting dormitories. There were ten people within these two dormitories and they all had curtains around the beds that were collapsible. Each patient had wardrobe space and the décor of the dormitory was satisfactory. Toilets and bathrooms were locked to prevent people wandering into them. The décor could have been improved within the toilet area. There was an excellent hydraulic bath which ensures that there was no manual handling for bathing. There were specific bathing times but four of the patients were incontinent and therefore have a bath on a more regular basis. The minimum requirement was once a week.

There were specific areas for dining. There was a dining room which was off the main body of the ward which was fully equipped and had a very pleasant environment. There were two lounge areas, one specifically for smoking and one non-smoking. There were comfortable seats in each lounge and there were specific chairs for the four people who were fully dependent. The décor was satisfactory in this room and the patients had access to TV, radio, newspapers and books. On the day of the inspection a number of the patients were listening to their own radios.

The nurses' station was situated next to the dormitory. There was adequate space for report writing but the confidential nature of the office was questionable as it was not fully enclosed. It was accessible to the patient group and had good observation points. There was a telephone system but no IT.

The clinical room doubled as the nurses' station. Medical equipment was stored in this room as was the defibrillator, oxygen and suction machines. The defibrillator equipment was checked on a weekly basis. Clinical waste was disposed of by a contractor.

There was a large storage room within the ward where patients' possessions were kept. All of the patients had accounts for their money in the general office and there was daily money allocated to each patient which was signed for. There were no Wards of Court on this ward. There was adequate storage for notes and medication was stored in a locked trolley. Catering was all facilitated off the ward in a separate facility.

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### STAFF TRAINING

The training programme available for staff on this ward has a large emphasis on training for nurses. All mandatory training is undertaken and there is specific training available in bereavement counselling, teaching assessing and clinical practice.

The staff on the ward feel uncertain about the future of the ward. They are not clear whether there are plans for it to continue or if it is going to be moved or closed. As well as their own feelings on the matter, they also shared concerns for the patient group and their families. Other issues for them were the environmental issues and that there is no recognised maintenance programme.

## ST. FINTAN'S HOSPITAL, PORTLAOISE

### REHABILITATION WARD

*Date of inspection:* 8th June 2005

*Number of beds:* 16 male, 11 female

### DESCRIPTION

The rehabilitation ward is an integrated ward within St. Fintan's Hospital. It caters for patients who have been in hospital for lengthy periods of time. It has recently become the responsibility of a consultant psychiatrist with a special interest in rehabilitation. There has been considerable effort to assess the patients in this ward for relocation to high support hostel and to develop a rehabilitation service, which would also incorporate the high support hostels. However, there is no multidisciplinary rehabilitation team apart from a staff nurse, NCHDs and the consultant psychiatrist. There are plans to transfer two more nurses to the service in the near future. Adjacent to the rehabilitation ward there is a 3- to 4-bed ward which is due to open within the next two months. This represents a creative and appropriate use of part of the old hospital building. It is a pleasant, homely ward of adequate size with a separate entrance. This will provide intensive rehabilitation to patients transferred from the rehabilitation ward and to patients from the acute admission wards who require intensive rehabilitation.

### REFERRAL

Referral to the rehabilitation ward is made by consultant psychiatrists or by patients' key workers to the consultant psychiatrist with responsibility for the rehabilitation ward. The rehabilitation consultant reviews the patient prior to transfer. On occasion the nursing staff from the rehabilitation ward will also review the patient.

### PROCESS OF ADMISSION

There is no admission policy specific to the rehabilitation service. All decisions to admit or transfer to the ward are made by the consultant psychiatrist with responsibility for the ward. Admissions and transfers are discussed with the patient and occur only with the patients consent. There are no involuntarily detained patients on the ward. There are no admissions or transfer of children under 16 years to the ward. Patients with intellectual disability are not admitted, however there are a number of patients with moderate intellectual disability on the ward. These patients have been assessed by the consultant psychiatrist in intellectual disability and are awaiting transfer to more appropriate services if places become available.

A full physical and mental state examination is completed on admission to the ward and a collateral history is taken where appropriate. An initial treatment plan is documented in patients' clinical file. A key worker is allocated to patients on admission.

### CARE PLAN

There is a multidimensional nursing care plan. There is no multidisciplinary input to this ward and therefore no formal multidisciplinary care plan. A medical treatment plan is documented in the clinical file. The community placement questionnaire has been completed on all patients in the ward and this outlines accommodation needs and forms the basis for planning for appropriate community placement for patients. There is no formal discharge policy or planning on the ward. Following discharge, a discharge letter is sent to the patient's GP and follow-up is arranged through the sector community mental health nurse.

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#### NURSING PROCESS

The nursing staff use a nursing model developed by the Laois-Offaly Mental Health Service. It is not appropriate to a rehabilitation service and the risk assessment contained in the model is unsatisfactory.

There is a comprehensive key worker system in place that aims to provide continuity of staff. The patients are aware of their key worker. There is an observation policy available on the ward. All nursing staff wear identification badges.

#### ACCESS TO THERAPY

There is no access to a multidisciplinary team. The consultant psychiatrist may refer patients to the sector occupational therapist, psychologist, social worker or addiction counsellor. The NCHD attends the ward and reviews patients daily. The consultant psychiatrist attends the ward weekly for a team meeting and to review patients. Comprehensive six-monthly physical and mental state examinations are carried out. Patients have access to surgical and physical assessment, radiology and laboratory through the general hospital.

#### ACCESS TO THERAPEUTIC PROGRAMMES

Patients attend an activation ward on the hospital grounds known as "occupational therapy". There is no occupational therapist input there, however, and the activities are run by nursing staff. The activities are not needs-based and consist of repetitive tasks such as packing serviettes into containers and cushion filling. Knitting, cooking and painting are also available. The ward is unsuitable as an activation centre and is too small. There are plans to move the ward to another existing building on site.

#### CLINICAL RISK MANAGEMENT

There is no overall clinical risk management policy available on the ward. However, there were individual policies on deliberate self-harm, patients missing from the ward, the management of violent episodes, and other health and safety issues. It was stated that there are problems with patients returning from leave

intoxicated with alcohol, but there is no policy available to staff on alcohol and illegal drugs. Restraint and seclusion are not carried out on this ward. Ongoing individual clinical risk assessments are not documented in the patients' files. Risk assessment forms part of the community placement questionnaire and is available only as a once-off assessment. There is a comprehensive incident reporting system with feedback to the staff and patient and an annual audit carried out on all serious incidents. Incident debriefing is also available.

#### UNIT MANAGEMENT

There are no transfers in or out of the ward due to bed shortages. Patients are sometimes discharged and admitted to the acute ward for management of illness relapse. There is an open door policy and CCTV is not used.

There are four nursing staff on duty during the day (three staff between 1800h and 2030h) and two nursing staff (one male and one female) at night. Nurse staffing is by central rostering but effort is made to maintain consistency of staffing where possible. There are 2.5 whole time equivalent household staff on duty daily.

There is a formal induction of staff newly arrived on the ward, with written information available about the function of the ward. Secretarial assistance is available to staff in the ward. Phlebotomy is carried out by the NCHD. There is no waiting list for this ward. There are four to five patients awaiting immediate transfer to a high support hostel, but no places are available. It was stated that there are constant difficulties with the provision of basic maintenance of the ward. Visiting time is open. Patients are free to make their own snacks; tea and coffee and meal times are at appropriate times.

#### SERVICE USER INVOLVEMENT

Information on treatment and therapies is available to the patients. There are information leaflets available about the service on the ward. There is a complaints policy in place and a complaints officer in the service. There is no suggestion box on the ward but there is a suggestion box in the main hall of the hospital. There

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is access to the Irish Advocacy Network and an advocate visits the ward every week. Service users spoken to on the day of inspection reported that they were satisfied with the service provided. They valued the ability to be able to come and go from the ward when they wished.

### RECORDS

The clinical files had patients' names on each page, the file was neat and tidy with up to date progress notes and treatment plans. However the medical staff's signatures were often illegible or were merely initials. In some cases there was no title of personnel recorded.

The nursing records were up to date and were filed at the front of the clinical file. Again, many nursing notes were merely initialled.

The medications were legible and used generic names. Many prescriptions were initialled or the signatures were illegible which is unacceptable. The depot medication and as required medication were prescribed in the same location as regular daily medication which had the potential to cause confusion. No signature bank was available for medical or nursing staff.

### ENVIRONMENT

The rehabilitation ward was located on the first floor of St. Fintan's Hospital. There was access to a lift. The ward was quite large and occupies most of the first floor space. There were three communal areas – a non-smoking living room, a smoking room and a dining area. The décor and furniture were poor. Some of the rooms were separated only by partial high partitions. Other single male rooms were very small and had limited light.

Some attempts had been made recently to paint some of the areas. There was limited access to shower and bathing areas which results in a queuing system. Ongoing maintenance for the ward was by referral to central maintenance department. There was access to a garden area on the ground floor. There was no sheltered area for smoking in the garden. The ward was unsuitable for its purpose.

## PORTLAOISE DAY CENTRE (THE ACTIVATION CENTRE)

*Date of inspection:* 8th June 2005

*Number of beds:* 13 places

### DESCRIPTION

This day centre is located on the grounds of a hospital in a stand-alone building. It has a separate entrance and currently has 13 people attending. The group attending is mainly older female patients. They are reviewed by the sector team at the weekly day hospital meeting and also attend outpatient clinic. A weekly programme is facilitated by 1.5 whole time equivalent nursing staff. This is supplemented with sessional staff, i.e. VEC teachers who provide yoga, pottery, numeracy and literacy skills. This is reviewed annually. The majority of patients are transported to and from the day centre by taxi as many of the attendees live in areas with no public transport. It was reported that there is difficulty moving patients on to more age appropriate services. There are some difficulties in referring patients to the old age services. The staff are to be commended on their ability in raising funds to pay for additional services and resources.

## OCCUPATIONAL THERAPY AREA

*Date of inspection:* 8th June 2005

*Number of beds:* 42 places

### DESCRIPTION

Although named Occupational Therapy there is no input from occupational therapists to this service. This was a single-storey building located on the grounds of the hospital.

It provides repetitive craft-based activities for 42 people. The attendees come from eight group homes, Rehabilitation Ward and Ward 6 in St. Fintan's Hospital. There are two staff nurses staffing this area, one whole time equivalent care attendant and there is also access to a carpenter teacher two days per week. This area aims to be self-financing by repaying the HSE Midland Area for stock after an annual sale of work at Christmas. Attendees are paid a comforts allowance of €15 per week.

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## DAY HOSPITAL FOR PSYCHIATRY OF LATER LIFE, PORTLAOISE

*Date of Inspection:* 8th June 2005

*Number of places:* 10 places

## DESCRIPTION

The Day Hospital for Psychiatry of Later Life (POLL) is located close to St. Fintan's Hospital, Portlaoise. It also serves as the services headquarters and outpatient clinic for the POLL service. There are plans to run satellite clinics in all sectors. Due to lack of space, a maximum of 10 clients can attend the day hospital daily.

## PROCESS OF ADMISSION

All referrals to the service are triaged through the team coordinator and are discussed at the weekly multidisciplinary team meeting. There is no waiting list for the service. Emergency referrals are seen within 48 hours. All referrals are discussed with the client's GP and family. At present there are approximately 300 clients on the caseload of the service.

## CARE PLAN

Each client has a multidisciplinary care plan. There are five community mental health nurses, an occupational therapist and social worker, consultant psychiatrist and two NCHDs on the multidisciplinary team. There is a vacancy for a psychologist.

## ACCESS TO THERAPY AND TREATMENT

Therapy in the day hospital includes relaxation therapy, newspaper reading, gardening and reminiscence therapy. There is also individual therapy with the occupational therapist and social worker, if appropriate. Each client is reviewed by the medical staff each day they attend. The service does not have a psychologist.

## ENVIRONMENT

The day hospital premises are extremely small with a thoroughfare through the main sitting and dining room. There are insufficient interview rooms. There is a pleasant sensory garden beside the day hospital.

## ERKINA HOUSE, RATHDOWNEY

*Date of inspection:* 9th June 2005

*Number of beds:* 17 places

## DESCRIPTION

Erkina House is located in the town of Rathdowney. It was a former convent and is an imposing two-storey house with front and rear gardens. The rear garden is secluded and maintained to an exceptional standard. The house was bought by the Midland Health Board and opened as a residence with 24-hour nursing staff supervision in 1996. There are a total of 17 places. The majority of residents have been resident in the house since it opened. Fifteen of the current residents are aged 60 years and older. The oldest resident is 76 years. The house also has a number of other uses; it acts as an outpatient clinic and a day service and, at night, local branches of mental health voluntary groups use the house for meetings.

## REFERRAL

All referrals to the residence and day services are provided via the consultant psychiatrist for the Birr sector.

## PROCESS OF ADMISSION

All admissions to the residence come via the Acute Unit in Portlaoise. There is no formal admission policy or written inclusion or exclusion criteria. The residence beds are used primarily for users in need of rehabilitation. There are no crisis admissions. There is one dedicated respite bed which is currently being filled on a long-term basis.

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### ASSESSMENT ON ADMISSION

The case notes follow the new resident from the hospital setting. All residents are registered with the local GP and access that service independently. All decisions to admit are taken by the consultant psychiatrist. The resident is introduced to the residence and invited to visit prior to discharge. The consultant reviews the resident at the next available outpatient appointment. The treatment plan continues from the hospital episode of care. The NCHD reviews each resident every six months following admission.

### CARE PLAN

There are no multidisciplinary care plans in place. There are separate nursing care plans and medical treatment plan. Given the age profile of the residents there is no active care plan reviewing. There were three discharges last year to elderly care services. There are three residents who would benefit from accommodation with lower levels of support.

### NURSING PROCESS

A key nurse system has been introduced. The nursing model in use is consistent throughout the HSE Area. It does not contain a risk assessment. This will need to be adapted to provide a rehabilitation need of assessment.

### REHABILITATION TEAM

A rehabilitation team is being established. The Inspector was given to understand that the service will transfer from the general adult sector team to the rehabilitation team in the near future. Currently the residents can be referred to members of the multidisciplinary team on the general adult sector team by referral. The consultant psychiatrist in conjunction with the nurse reviews the residents every fortnight. Urgent assessments are completed by the NCHD in the intervening period. All residents have medical cards and are registered with the local GP.

### INVOLVEMENT IN REHABILITATION PROGRAMMES

There is a weekly diversional activities programme provided in the residence. It caters for residents and day attendees. Dedicated nursing staff facilitate this programme.

### CLINICAL RISK MANAGEMENT

The residence is governed by HSE Midland Area policies in this area. There is no localised policy. There is no clinical audit in place.

### UNIT MANAGEMENT

There is no evidence to suggest that the residence beds are used for other reasons than long-term care. The residence however does provide additional services. It serves as a day service to the Birr catchment team, including Rathdowney. There are 25 day attendees on the books, with an average daily attendance of seven or eight. The day attendees are transported to the residence by minibus from around the sector. Erkina House also serves as an outpatient clinic once a fortnight and is used by the mental health associations GROW and AWARE to hold public weekly meetings. These are advertised in the local paper and in the local parish newsletter.

There is one CNM2 and two staff nurses per day reducing to one staff nurse and attendant at night. During the day there is a full-time cook and 1.5 whole time equivalent care attendants. There is additional nursing staff dedicated to visit day services activities programme. The staff self-roster and relief and holiday staff comes from the central hospital panel.

The residence has many functions and this confuses its overall ethos. Annual activity levels are collated but there is no annual report for the residence service. The policies and procedures are HSE Midland Area wide and not dedicated to the residence service. There is a formal induction for new residents. Staff have a smart casual dress code. Levels of resident satisfaction are measured anecdotally by staff. There is no formal waiting list. In 2004 three discharges took place to elderly care centres. The maintenance of the residence is the responsibility of the HSE Midland Area.

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#### HOUSE RULES

The house rules are designed by the sector management team and are reviewed annually. Visitors are encouraged and visiting time is very flexible. Residents are allowed to leave the building unsupervised. However they inform nursing staff and this is recorded in the day report. Residents do not have a front door key and bedrooms are locked during the day. The bathroom doors are lockable.

Given the many functions of the residence there is one whole time equivalent cook and an industrial kitchen in place. Meals are prepared for 25 people per day. Residents can be involved in washing up and setting tables but they have no input into menu planning. Residents must request access to drinks during the day. Many use local coffee shops.

The rooms are all located upstairs. There are single rooms and two 4-bed rooms. All the rooms have access to a sink. There is no set bedtime and residents can have a lie-in at weekends. The option of choosing where to sleep is accommodated if possible. Residents' belongings are listed on admission only.

On the day of inspection, residents had not received official documentation regarding recouping of monies paid for long-term care. A number of residents have bank accounts or post office accounts, which they can access independently. Nursing staff holds other monies and a daily allowance is given to each resident. A number of residents have money collected for them by nursing staff. Residents are not asked to pay for furniture and fittings for the residence.

Residents use local shops to buy clothing. They do not have free access to the utility room, which has industrial-type machines. Some laundry needs are outsourced back to the hospital.

The location of the residence in the centre of town facilitates residents to access local shops, bookies and public houses. There is a town link bus service to Portlaoise town and also a railway station. All residents have bus passes.

#### SERVICE USER INVOLVEMENT

It was reported that most residents are registered to vote. Some residents have accessed national health initiatives like BreastCheck and the Stop Smoking initiative.

Residents are encouraged to discuss complaints locally with nursing staff and medical staff. The HSE Midland Area policy on complaints procedures is in use and there is a complaint box in the residence. Community meetings are not a feature of the residence or the day programme. The advocacy service has visited on one occasion.

#### RECORDS

The residents' notes consist of combined medical and nursing notes. Other members of the multidisciplinary team input into the records as required by letter. The case notes follow the patient from hospital through the community residence. The medical notes section contained evidence of a treatment plan and regular review. The notes reviewed during the inspection did not contain a patient identifier on each continuation sheet or legible signatory. The nursing notes were identified by blue paper. They contained a care plan and there was evidence of regular review. There was no signature bank in place to identify staff recordings. There were no residents self-medicating. The card index system was in order. All changes in medication is noted to the GP and all prescriptions are filled by the local pharmacy.

#### ENVIRONMENT

The house was maintained by the HSE Midland Area maintenance staff. This arrangement was reported to be satisfactory. The house was comfortable with adequate standard of hygiene and decor. Residents had adequate access to personal storage space. The bedrooms were locked during the day. The age and structure of the building renders it difficult for residents with decreasing mobility. The bathrooms did not facilitate independence. The staff were reluctant to introduce bathing aids so all non-ambulant residents were transferred to elderly care centres. Consideration was given to installing a lift. A decision was taken not to introduce one. There was adequate nursing office space for night and day staff.

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### STAFF TRAINING

Nursing staff receive training in cardio-pulmonary resuscitation and manual handling as part of the nurse education service.

### FUTURE PLANS

A rehabilitation service is in its infancy with the initial team members being appointed. There are plans to develop a rehabilitation service that will meet local needs.

### BIRCHWOOD, TULLAMORE

*Date of inspection:* 8th June 2005

*Number of beds:* 9 male, 6 female

### DESCRIPTION

This unit is an integrated residence with 24-hour nursing staff supervision, with 15 residents, in the campus of health area offices and geriatric facilities. It is located close to the centre of Tullamore town.

### REFERRAL

Referrals to the residence are made by consultant psychiatrists within the catchment area directly to the consultant psychiatrist with responsibility for the residence. All referrals are assessed by the consultant psychiatrist. On occasions the nursing staff in the unit may also assess the client.

### PROCESS OF ADMISSION

There is no specific admission policy for the residence. Residents are usually admitted for 24-hour supervision following discharge from hospital. Admissions also come from medium and low support residences, when this is felt to be appropriate. There are no admissions of people who are acutely ill. Respite is occasionally offered in the residence. There is no respite policy but there are plans to develop a respite policy in the context of the developing rehabilitation service. All residents have a mental

state examination and a collateral history is obtained where appropriate. The decision to admit the person is discussed with the client and his or her family where appropriate.

### CARE PLAN

There is a nursing care plan in operation which does not meet the needs of residents. It was subsequently reported to the Inspectorate that all residents had care plans drawn up in conjunction with their respective key workers in 2001 and repeat care planning was carried out in 2005, again with the key worker.

There is no multidisciplinary care plan in operation. A treatment plan is documented in the clinical file by the medical staff.

### NURSING PROCESS

There is a nursing model which has been devised by the Laois-Offaly mental health service but it was felt by staff that it was not appropriate to the needs of residence residents. There is a key worker system in operation. All staff wear identification badges.

### REHABILITATION TEAM

There is no rehabilitation team available for the residence. However, it is planned that the developing catchment rehabilitation team will take over responsibility of the residences as part of the rehabilitation service. Initial assessments on residents' needs have been commenced by the consultant psychiatrist with responsibility for rehabilitation. Access to a social worker, psychologist, addiction counsellor or occupational therapist is through referral to the sector multidisciplinary team. The consultant psychiatrist reviews the residents every four months, and more often if required. All residents are registered with a GP of their choice.

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#### INVOLVEMENT IN REHABILITATION PROGRAMMES

The majority of residents attend a community health centre or a workshop. There is no formal assessment of occupational or activation needs. The residents are able to choose whether or not to attend either facility.

#### UNIT MANAGEMENT

No residents are transferred to or from other units due to bed shortages. The residence is not used for any purpose other than as a residential unit. There are two nursing staff on duty during the day and one nurse at night. The residence is self-staffing. There is one household staff on duty during the day and at night. There is no formal induction of new staff. The ethos of the unit is stated as promoting independence. The policies and procedures of the mental health service are available in the residence. Nursing staff do not wear uniforms. There is no formal waiting list for the residence. There are a number of residents discharged each year to lower support residences. Maintenance is available for the residence.

#### HOUSE RULES

There are open visiting times and residents are encouraged to make visits to their families. Residents do not have their own front door key but are free to come and go from the residence as they wish. Bedrooms are left open. Meals are provided by central catering and residents have free access to the kitchen. There are no set bedtimes. Where possible, residents manage their own finances. The staff manages the finances of most residents but residents have access to it on request. Residents purchase their own clothes, usually accompanied by a staff member. There is good integration with the local community. The residents access cinema, pubs, shops and other areas as they wish. The residence is within walking distance of the town centre.

#### SERVICE USER INVOLVEMENT

There is information about the mental health service and local services for the residents. There is a complaints policy which is available in the residence. Residents stated that they liked living in the residence and enjoyed their independence. They particularly liked being close to local facilities.

#### RECORDS

The standard of record-keeping was good. Each progress note was dated and signed and was legible. All records were kept in one clinical file that was neat and tidy. Medication was provided in individualised blister packs. The medication sheets in the residence had not been rewritten in some cases for two years. No resident is self-medicating.

#### ENVIRONMENT

The residence had previously been a facility for care of the elderly and retained some institutional features. However, considerable effort had been made to make it homely and comfortable. The sitting room was comfortable and had a TV, DVD player, music, books and papers available. There was a smoking room in the residence with ventilation. The dining room was large and bright and the kitchen was open and welcoming. Residents had free access to all areas. There were double and triple bedrooms, which did not have en-suite bathrooms. The bedrooms had adequate individual storage and each room had an abundance of personalised items and ornaments. There were adequate gender specific bathrooms and toilets as well as a new disabled shower and washing facility. There was a large private garden surrounding the residence. This is currently undergoing extensive landscaping and planting.

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## ST. LOMAN'S HOSPITAL, MULLINGAR

### FEMALE ADMISSION WARD

*Date of inspection:* 13th June 2005

*Number of beds:* 25 female

#### DESCRIPTION

The female admission ward is a locked 25-bed ward which is temporarily located on the first floor of the main psychiatric hospital. The original female admission unit is currently being renovated and is due to be ready in December 2005. There are currently six detained patients and one Ward of Court. There are about eight patients awaiting alternative accommodation who could be discharged if this were available.

#### REFERRAL

The majority of referrals come from GPs, outpatient clinic, A&E and by self-referral.

#### PROCESS OF ADMISSION

There is an admission policy. Four clinical teams admit to the ward. Children under 16 years have not been admitted to the ward in the last year. No patients have been admitted who have moderate intellectual disability. There is a community alcohol detoxification (CAD) programme, which is a day programme available through the mental health service and this has reduced the number of female patients admitted for alcohol detoxification. Each patient receives a psychiatric assessment and physical examination on admission. The decision to admit a patient is made by the NCHD. The consultant psychiatrist is contacted if the patient is a detained patient or if there are problems with the admission process. The patient's GP is not routinely contacted regarding a patient's admission. A collateral history is obtained from patients' family if possible. Each patient is reviewed within 24 hours of admission by a consultant psychiatrist. An initial treatment plan is documented in patients' clinical file. Patients are nursed in their night clothes until reviewed by the consultant psychiatrist.

#### CARE PLAN

The only formal care plan for patients is the nursing care plan. There is no formal discharge plan but there is a discharge checklist for nursing staff when patients are being discharged. A discharge letter is sent to patients' GPs immediately on discharge.

#### NURSING PROCESS

The nursing model has been developed by the Longford-Westmeath mental health service and is based on the Roper Logan Tierney model. Within this care plan problems are identified and interventions are outlined. There are also regular reviews of the care plan. Patients are consulted about their care plan and are able to sign it. There is currently a working committee reviewing nursing care plans. There is no key worker system in operation. However, there is a complicated system where designated nurses are assigned to write up care plans for patients in a particular sector and other nurses are assigned to the sector consultant psychiatrist for every day care of the patients under that consultant psychiatrist. There are five nurses on duty during the day with one or two household staff. There are three nurses on duty at night; however, one of these nurses may be deployed elsewhere in the hospital depending on need.

#### ACCESS TO THERAPY

Access to a psychologist, occupational therapist or social worker is by referral letter only, even within the multidisciplinary team. There are weekly multidisciplinary team meetings. Access to the addiction counsellors is usually on discharge. The consultant psychiatrist and NCHD attend the ward daily. There is access to radiology and laboratory services. For medical and surgical assessment patients must wait with staff, often for extended periods, in A&E in the general hospital. This can cause difficulties if the patient is disturbed and causes staff shortages on the ward.

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#### ACCESS TO THERAPEUTIC ACTIVITIES

Patients may be referred to the activation unit which is located on the grounds of the hospital. Six patients were attending the activation unit at the time of inspection. There are no therapeutic activities carried out on the ward.

#### ECT

ECT is carried out in the day ward of the general hospital. There is an ECT policy, procedure and register available. There is a consent form signed by the patient and the consultant psychiatrist. There is no written information available for patients. There is a nursing procedure and checklist. A number of nurses are trained in ECT procedure and there is a designated ECT consultant. ECT was documented in the patients' clinical files with regular reviews during the course of ECT.

#### SECLUSION

Seclusion is carried out on this ward. There is a seclusion policy and register which was up to date. Length of time of seclusion was specified and it was signed by the consultant psychiatrist. There was a nursing observation checklist. The seclusion room was bleak, but safe; clean and well ventilated. There was no direct access to a toilet. There was an observation panel in the door but no communication facility for the patient. Refractory clothing was not used. There was no CCTV used in the room.

#### CLINICAL RISK MANAGEMENT

All policies on alcohol and illegal drugs, patients missing from the ward, the management of violent episodes, and searching patients were available. Some staff were trained in control and restraint techniques, cardio-pulmonary resuscitation and breakaway techniques. There was a minimal clinical risk assessment in the nursing care plans. A formal risk assessment (HCR 20) is available if required. There is a formal system of reporting serious incidents and an annual audit is carried out. Debriefing is available for staff if required. There is no formal multidisciplinary review of serious incidents. There is a location-based alarm system.

#### UNIT MANAGEMENT

Patients are transferred to another ward to sleep if there are bed shortages in the admission ward. There are long-term transfers of elderly patients by the Psychiatry of Later Life (POLL) team to St. Bridget's Ward. Patients are allowed off the ward if authorised by the consultant psychiatrist. The ward entrance door is locked. There is no waiting list for the ward. The ward is used for clozapine monitoring of outpatients and four outpatients receive depot medication on the ward. Nurse staffing is by central rostering and nurses wear uniforms. There is no ward clerk and phlebotomy is performed by NCHDs. There are eight patients waiting for placements in alternative accommodation. There are difficulties in obtaining essential maintenance. Visiting times are open. Meal times are at usual times and there are snacks between meals. There are no facilities for patients to get their own snacks or drinks.

#### SERVICE USER INVOLVEMENT

There was information on the treatment and services for patients available on the ward. There was a large notice outlining patients' rights under the Mental Treatment Act. There was information on complaints procedure and a suggestion box. A patient advocate from the Irish Advocacy Network calls to the ward regularly. There is a weekly GROW meeting which patients from the admission and long-stay wards may attend. Staff also attend these meetings.

#### RECORDS

The patients' clinical files were reasonably tidy. Entries did not always have the full name and staff designation, but entries were signed and dated. There were treatment plans in the files. Entries were made by consultant psychiatrists and NCHDs every two to three days. There were progress reports from psychology in one file inspected. The nursing notes were legible and up to date. The prescriptions on the medication sheets were initialled but not signed which is not acceptable. There were no staff signature banks.

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## ENVIRONMENT

The ward was long and narrow with dormitories at the end. The state of décor was very poor. There was paint flaking from almost all walls in the ward. There were damp patches along the walls in some areas. The bathrooms and toilets were in a particularly poor condition. There was no disabled access. The lighting and ventilation was adequate. There was a poorly decorated and furnished visitor's room that was also used for team meetings. There was no direct access to an outside area and the door to the ward was locked. There were two interview offices and two very small nursing offices. There were three dormitories and two single bedrooms. There were curtains around each bed and each bed had a wardrobe but the décor was poor. There was a dining room with adequate space for one seating. There was an open plan lounge area that had paint peeling from the walls, which were discoloured. TV, radio, books and newspapers were available. There was no other lounge or quiet area for patients.

## MALE ADMISSION WARD

*Date of inspection:* 13th June 2005

*Number of beds:* 25

## DESCRIPTION

This is a 25-bed unit for male acute admissions. On the day of inspection there were seven patients on Temporary status. The unit is described as an open facility, but was locked on the day of inspection and has been for some time.

## REFERRAL

The sources of referral for this unit are A&E, GPs, outpatient clinics and self-referrals. Referrals are made by a referral letter or GPs contacting the ward. During office hours, the sector NCHD assesses the referral. Out of hours, the NCHD on call carries out the assessment. The assessment takes place on the unit and the decision to admit is made by the NCHD, sometimes in consultation with a consultant psychiatrist. On occasions, nursing staff may assist with the assessment.

## PROCESS OF ADMISSION

People under the age of 16 years are rarely admitted to this unit. If this is the case, then a child and adolescent psychiatrist maintains clinical responsibility for the patient. People with a moderate intellectual disability are admitted to the unit only if there is evidence of a co-morbid psychiatric illness; they are initially looked after by a sector team and then referred to the service for intellectual disabilities. The unit continues to admit people for alcohol detoxification and the numbers of these admissions are high. It was reported that patients are offered an outpatient detoxification program. The unit also admits people who are in social crisis.

On admission a full assessment is carried out by the medical and nursing staff. This includes a physical examination and a collateral history is obtained from any family member who had accompanied the person to the unit, or from An Garda Síochána if appropriate. Alternatively, the next of kin is contacted with the patients' permission. It is not common practice for the unit to communicate with patients' GPs unless patients are involuntarily detained. The nursing staff explain to the patient why they were being admitted, depending on their mental state. The initial treatment plan is documented in the case notes and in the nursing notes.

The patient is reviewed by a consultant psychiatrist within 24 hours. It is policy on the unit that all patients admitted to the unit are placed in night attire for up to a week. The observation level is part of the treatment plan and the patient is either placed on general observation, close observation or special observation. The unit is currently developing a key worker system but it was reported by staff that this is being delayed by an industrial relations issue. Subsequently senior nurse management stated that they are not aware of any issues. At present staff are allocated to sectors and the senior staff nurse takes responsibility for each sector and the patients are then allocated to staff within that sector.

## CARE PLAN

The care planning on this unit is nursing linked only to the psychiatrist notes. There is no multidisciplinary involvement in the care planning, the needs are identified by a nursing assessment. The nursing and

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medical staff refer to other members of the multidisciplinary team if it is felt appropriate. Goals and objectives are identified by the nursing staff. The nursing care plans are reviewed on a regular basis and that may range from daily to fortnightly. The patient is involved in the care planning by being interviewed in one-to-one sessions and some patients sign their care plans. There is no documented evidence of family or carers being involved in the care plan.

The process for discharge of a patient from this unit is decided at the team meeting. Patients' GPs are sent a letter of discharge within three days, as are family members. Community teams are present at the team meetings but also receive a phone call to inform them of the discharge of a patient.

### NURSING PROCESS

The nursing model used is the Roper Logan Tierney. It was described as working satisfactorily on the ward. It is implemented by the team nurse assigned to each patient. A risk assessment element has recently been introduced and there is an observation policy in place. There was some concern expressed by staff regarding close observation, which involves 15-minute checks. This needs to be discussed with management and resolved. The staff are identified by their name badges.

### ACCESS TO THERAPY

The majority of care on this ward is provided by medical and nursing staff. The consultant psychiatrist refers to psychologists, occupational therapists and social workers. There is an activity centre on the site of the hospital and the CNM2 can refer patients to this unit if their mental state is relatively stable. There are no specific counsellors with input into this ward. People can access an alcohol counsellor in the community. Three sector consultant psychiatrists admit to this ward and the substance misuse consultant psychiatrist may also admit. The consultant psychiatrist reviews patients two or three times a week. The NCHD looks after the physical condition of the patients and refers to A&E if necessary. Patients are referred to the county hospital for any laboratory tests and X-rays.

### ACCESS TO THERAPEUTIC PROGRAMMES

There are no therapeutic groups in evidence on this unit at the present time. It was pointed out by the CNM2 during the inspection that a room for the purpose of activities would be beneficial to the patients on this ward but at present there is no such facility. Patients who are deemed to be well enough attend the activity centre on the campus but those that are too unwell cannot access the centre.

### ECT

ECT is carried out at the county hospital in Mullingar. There is an ECT policy and procedure in place and the consent for ECT is obtained on the unit by the medical staff. There is information available for the patients who are going to receive ECT and there is a nursing procedure and checklist in place. Nursing staff on the unit escort patients to the county hospital.

### CLINICAL RISK MANAGEMENT

There is no formal clinical risk management policy. The risk management department have a policy in place for health and safety issues. There is little attention to the clinical risk assessment of a patient. There is an alarm system in operation; however, although staff carry individual alarms, the receivers are situated in the reception and the nurses station which are both at extreme ends of the ward. This is far from satisfactory.

There is a policy in place about alcohol and illegal drugs, and patients who are absent without leave from the ward. There is a policy on the management of violent episodes but there is no consistent approach to restraining a patient. There is no mechanical restraint used on the ward. There is no physical restraint policy and the only documentation of restraint is the incident form and what is entered in the nursing notes.

The decision to give rapid tranquillisation is made by the consultant psychiatrist. There does not appear to be a policy on giving a patient medication without consent. However there is a very detailed consent policy produced by the HSE Midland Area. The

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Inspectorate was informed that medication is not given against patients' consent until it was discussed with a consultant psychiatrist. There is a policy in place on searching patients' belongings. This seems to be a very clear procedure and the patient is informed and present throughout this process. This also applies to patients' room and bed areas.

The HSE Midland Area have provided a very thorough policy on the management of violence. However, there does not appear to be any systematic policy regarding the use of restraint, de-escalation or breakaway techniques.

Staff receive cardio-pulmonary resuscitation training. There is some training on the medication used in psychiatry which is usually provided by pharmaceutical companies.

There are no clinical risk assessments documented in the patients' notes. There are serious untoward incident forms filled in for any incident on the unit and these are followed up by the risk management department.

#### UNIT MANAGEMENT

There are occasions when patients are moved to the long-stay wards in St. Loman's Hospital due to shortage of beds. These people sleep out for the night and return to the admission ward the next day. The only long-term transfer is a patient in St. Edna's Ward, which is the locked ward on the hospital site.

There are limited activities available on this unit. Patients are allowed off the ward depending on their leave status. There is no enclosed garden area for the patients. The unit was locked on the day of inspection and the Inspectorate was informed that this was now common practice although it is described as an open unit. There is no documentation on locking doors completed on a daily basis. The policy dictates that the nurse in charge contacts the Assistant Director of Nursing to sanction the locking of the door but this does not happen. There is CCTV linked up to the main doors to the unit.

There are five nursing staff on duty during the day and three at night. There are an extra two nurses during the day at present due to a patient who is on

a two-to-one special nursing observation and one extra member of staff at night. This is not a self-staffing unit and is dependent on central rostering system, although there is a regular cohort of staff. There are two household staff on duty each day. The process for inducting staff consists of a tour of the ward and a general introduction to the patient group. The new staff are informed of where the policy folders are kept and are encouraged to read these. There is no ward clerk available to this ward, this is needed due to the large amount of administration work that the nursing staff are currently carrying out. Nursing staff are trained in venepuncture. There is no waiting list for this unit.

There is a maintenance programme within the hospital but unfortunately it is low priority within the HSE Midland Area due to the high demands for maintenance in the area.

There is free visiting access to the unit. There are set times for the meals and drinks are available between meal times.

#### SERVICE USER INVOLVEMENT

There is information available on the treatment and therapies the patients may receive, as well as information on their rights. These are displayed in the reception area, which is not always accessible to the patients. There is a complaints policy and the nursing administration follow up complaints.

There are no formal procedures for seeking patient or carers' views of the service and there are no community meetings in place on the unit. There is access to the Irish Advocacy Network. There is a weekly GROW meeting, which patients from the admission and long-stay wards may attend. Staff also attend these meetings.

#### RECORDS

Patients' name and ID number were on all pages of the notes and were legible. However the files were very untidy, there were a lot of loose pages contained in them and covers were ripped. There is no signature bank available and not all entries have full names and titles of personnel. There is no evidence

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of progress reports from allied health professionals. There are plans to combine all sets of notes. There was a treatment plan contained in the files but some were difficult to find. There was evidence that the consultant psychiatrist reviewed each patient on a weekly basis and that the NCHD reviewed patients more frequently. The nursing files were more tidy and legible. Entries had full names and titles of personnel and were dated. There was no signature bank available.

There is only space on the medication sheets to initial the prescription and the administration of medication. The prescriptions were dated and legible and generic names were used. Discontinuation of medication was signed and dated.

## ENVIRONMENT

This was a 25-bed male admission ward situated in the grounds of St. Loman's Hospital. The ward was all on the ground floor and the toilets had disabled access. There was good lighting and generally ventilation was good although one dormitory was very hot on the day of inspection. The décor was to a good standard. The noise levels were appropriate on the ward and there were information boards accessible to the patients. There was no dedicated visitors' area, so generally visitors either congregate around a patient's bed or in one of the lounge areas. There was no garden although there was a veranda that the patients can access.

The unit had a reception area but this was currently being renovated. The bedroom area was of a reasonable standard. There were five 4-bed dormitories and five single rooms. The curtains in the dormitories were collapsible. There was individual wardrobe space and the décor was generally of a good standard.

Toilets and bathrooms were of a good standard except for one toilet area. There was free access to the toilet and bathroom areas. There were two single rooms with en-suite facilities and there were overriding locks on all the bathroom and toilet doors. The dining area was a very pleasant room and there was enough room for all patients at one sitting. There was a cook-chill facility which was self-serve from the serving hatch. There was only one main lounge on the unit at the present time and this was

used for patients who smoke. Therefore there was a need for another lounge for the patients who do not smoke. There was access to daily newspapers, TV and radio. There were no books on the ward and the general décor of the lounge was satisfactory. There was no designated quiet area. There was a room within the unit that was multi-functional. It was noted that there was a general lack of interview rooms on this unit. A number of rooms doubled up for offices, interviews and meetings.

The nurses' station was located near the dormitory. This area was not conducive to confidentiality, it was open plan and nursing staff could be heard discussing patients. There was limited space for report writing and this area was often very busy and cramped. It was accessible to the patient group and there was a phone but no IT system.

The clinical room was situated off the main corridor of the ward. It had an examination couch and physical checks and blood tests were carried out there. There was a full range of medical equipment, cardio-pulmonary resuscitation equipment, oxygen and suction. Clinical waste was removed on a regular basis. There were staff facilities consisting of a changing room, small rest room, toilets and showers. There was also a small room available for students.

There was an issue on this unit for the storage of medical notes. The notes were contained in the CNM2's office and also in part of an unused reception area. Notes in the reception area were locked in a room. There was a need for the files to be stored in a more appropriate environment and as stated earlier there was a need for a ward clerk to maintain these files.

## ST. ANNE'S WARD

*Date of inspection:* 14th June 2005

*Number of beds:* 19 female

## DESCRIPTION

This ward is described as a continuing care ward and is located on the second floor of the hospital. It was locked on the day of inspection. It was stated that the ward operates an open door policy but that it may be locked at the discretion of the Clinical Nurse

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Manager. However, it appeared that it was locked on a continuous basis because of some patients may be at risk of harm if they left the ward. The ward caters for more disturbed female patients with enduring mental illness. There is an increasingly ageing population patient group in the ward, ranging in age from 28 to 86 years. Seclusion is available on this ward. There was a special nurse on this ward for the previous two weeks to manage a patient at risk of self-harm. On this inspection it was stated that a recent needs assessment had been conducted on all patients in the ward. The staff on duty on the day of inspection had only recently been appointed and were unaware of this assessment.

### REFERRAL

There are no direct admissions to this ward. Patients are usually transferred from the female admission unit, although this occurs infrequently.

### PROCESS OF ADMISSION

There is no ward-specific admission or transfer policy or a procedure for referral. There are no admissions of patients for detoxification or social crisis, nor are patients under the age of sixteen or with learning disability admitted to the ward.

### CARE PLAN

There is no formal multidisciplinary care planning on this ward. One consultant psychiatrist has clinical responsibility for all patients on the ward. There is a weekly meeting with the consultant psychiatrist, NCHD and the nursing staff. A needs assessment of patients on the ward has been conducted, which involved reviewing the Dependency Level Categorisation of all the patients based on physical and mental state assessment, age profile and a review of progress from medical and nursing perspectives.

### NURSING PROCESS

The nursing model used is an adaptation of the Roper Logan Tierney model. Many of the patients are elderly and the model was stated by staff to be appropriate to their needs although not ideal. Primary nurses develop nursing care plans and are responsible for reviewing them on a four-weekly basis. Nursing care plans do not contain a formal risk assessment. Subsequent to the inspection, the Inspector has been informed that, in fact, nursing and medical documentation does consider clinical risk management and that a number of the patients have had HCR 20 Risk Assessments completed as part of a needs-assessment process. As stated above, nursing staff were unaware of this on the day of inspection. There is a primary nurse system in operation where nurses are assigned to a group of patients; this system is linked into the rostering system. There is a hospital-wide observation policy. Levels of observation on this ward are general observation, close observation and special observation. Staff wear name badges and patients know the identity of their primary nurses.

### ACCESS TO THERAPY

Occupational therapist, social worker and psychologist access are not available on this ward. The consultant psychiatrist can refer to the appropriate sector health professional as indicated but the Inspector was informed that there was no access to psychology – there are no counsellors available. The consultant psychiatrist attends the ward two or three times a week and when required. Medical and surgical consultations are carried out in the Longford-Westmeath Regional Hospital and there are complaints by staff of delays in A&E. The staff were satisfied with access to laboratory and X-ray results. There are five nursing staff on duty during the day and two at night. In recent times a special nurse has been assigned during the day and night for a patient who has recently returned from another specialist service.

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#### ACCESS TO THERAPEUTIC PROGRAMMES

Eight of the patients attend the EALA Activity Centre. There were plans to develop a group-based programme on the ward.

#### ECT

ECT takes place on the day ward within the day hospital in the Longford Westmeath Regional Hospital and all documentation is held there.

#### SECLUSION

There is one seclusion room that was introduced in the last year. One patient has been secluded this year. The available seclusion policy had been revised on the 31st May 2005. A seclusion register was maintained. The seclusion record checked was satisfactory, with the date and time and the reason for seclusion all documented. The seclusion room was an ordinary single room located on the corridor that had been converted. There was plastic glass over the window but there were no blinds or curtains on it and it was quite bright. There was an observation panel in the door and the doors opened outwards. There was a soft-base bed in the room. The décor was poor and the lighting was not satisfactory, but ventilation was adequate. The seclusion room was currently being used as a nursing area. Refractory clothing is not used in seclusion and there is no CCTV in use on the ward.

#### CLINICAL RISK MANAGEMENT

The HSE Area policy on risk management was available. There is a personal alarm system in place, with an arranged staff response. There are hospital policies on alcohol and illegal drugs, patients absconding and on the management of violent episodes. There is no policy on rapid tranquillisation or on searching patients' belongings. Neither mechanical nor physical restraint is used on this ward. The HSE Midland Area conduct in-service training. Staff complained that there is difficulty in assessing in-service and said there was poor uptake of the many courses available. Clinical risk assessment is not documented in patients' clinical

files. The Inspector has since been informed that there is a separate folder containing a clinical risk assessment on each patient on the ward that is reviewed at least annually. Serious incidents are reported on incident forms that are used for both incidents and near misses, and these are sent to the Health Care Risk Management Service and audited by them. In addition all relevant documentation is sent to the Catchment Management Team, which reviews and investigates if required. Debriefing is available after a serious incident and reviews are documented in clinical files.

#### UNIT MANAGEMENT

There is no waiting list for this ward. Patients are not temporarily transferred to other units except for patients who, because of increasing age, become more dependent and are then transferred to St. Brigid's Ward. Over the last two years, one patient has been discharged home and four have been transferred to St. Brigid's Ward. Five beds have been closed and further closure of beds is envisaged.

Activities available on the ward include daily living skills, reminiscence, and newspaper groups. Patients are allowed off the ward by request. Some patients have to be assisted while using the lift. The ward is locked at all times although this was not documented. There is no CCTV in use on the ward. The ward is not used for any other purposes. There are two household staff on duty during the day. There was no formal induction of staff. There was a dress code. There was no ward clerk available and NCHDs perform venepuncture when required. Staff were reasonably satisfied with the availability of maintenance, the hospital switchboard service and domestic support.

Visiting times were described as flexible and relaxed. There was open access to the kitchen and meal times were at 0950h, 1200h to 1230h, 1645h and 1930h.

#### SERVICE USER INVOLVEMENT

Information on treatment and therapy is provided by the key worker. The notice boards display information on patients' rights and there are information leaflets available about the hospital in general but are not

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specific to this ward. There is a hospital-wide policy on complaints and there are information leaflets available on complaints. There are suggestion boxes on the ward and patients are encouraged to talk to staff. Carers or family opinions are sought when deemed appropriate. There are plans to introduce community meetings for patients, though these have not as yet occurred. There is a visiting advocate but the staff could not say how frequently the advocate visits this ward.

### RECORDS

Medication and allergies were clearly documented in the front of the clinical file. The hospital number and the names were present on the files. A nursing care plan was in use. All progress report entries were dated and signed; the staff name was not always legible. Patients were regularly seen by the consultant psychiatrist both within 24 hours of admission and a three-week intervals thereafter. There were infrequent written reviews by the NCHDs in the patient files. In some files inspected there were occupational therapist entries. The nursing reports were also satisfactory. With respect to medication, a 'patient prescription and recording sheet' was in use. The name of the drug was legible. Entries were dated and generic names were not used. The dose and intervals were clearly specified and were only initialled by the doctor. The administration sheet was legible and refusal of medication was noted. All the prescription sheets in this hospital carried only the initials of the prescribing doctor and the prescribing of medication in this way requires review.

### ENVIRONMENT

The size of the ward was quite restricted. It was located on the second floor of the building in an old psychiatric hospital. The kitchen had been identified as a problem area and was being addressed. There was lift access, thus making the ward wheelchair accessible. The lighting and ventilation were adequate. Apart from the central communal areas, which were pleasant and homely, in general the décor was drab. The corridors were very wide. Noise levels were quite high and there was little insulation. Information boards and leaflets were displayed throughout the ward. One of the major problems on

the ward appeared to be dampness. There is no separate designated area on the ward for visitors apart from an area on the ward corridor.

There were two dormitories with six beds, one dormitory with five beds, one single room and one room that could be used for seclusion. In the dormitory areas there were curtains around the beds on collapsible railings. There was individual wardrobe space but the décor was poor.

The décor was not satisfactory in the toilets and bathrooms. There was one shower for eighteen patients, and one bathroom that was not in use. There was free access to the bathrooms and there were specific bathing times for some patients. There were no overriding locks. There was space for all at one sitting in the dining room and patients could select their own food from the trolley; the kitchen staff served the food. The décor was again sparse in this area. There was open access to the kitchen and the dining room.

There was one lounge area directly opposite the nurses' station which had comfortable seating, newspapers, TV, video, radio and DVD and books were available and it was pleasantly decorated. There were plans to develop an unused room as a quiet area but at the time of inspection there was no quiet area. There were no separate interview rooms and the clinical room or the nurses' station were used for interviewing patients. The nurses' station was central, accessible, confidential and there was adequate space for report writing. There was one telephone line to the ward and there were no separate telephones for clients. Patients may make calls by arrangement with the nurse in charge.

In the clinical room there was an examination couch but as it was difficult to access, it was rarely used. Phlebotomy and urinalysis were carried out in the clinical room. There was an emergency trolley available in the ward, which is checked weekly. There was a unisex toilet and a wash-hand basin in the staff area, but no showers. There was access to a library/study room available on the campus.

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**ST. BRIDGET'S WARD**

*Date of inspection:* 14th June 2005

*Number of beds:* 27 female

**DESCRIPTION**

St. Bridget's ward is a locked 27-bed ward for care of elderly patients. The ages of patients currently in the ward ranges from 72 to 90 years. There are currently three detained patients on the ward. The emphasis of care is on patients' physical needs, but no patient is bed-bound. The majority of patients in the ward have a diagnosis of dementia. The consultant for the Psychiatry of Later Life (POLL) has clinical responsibility for all patients on the ward.

**REFERRAL**

All referrals to St. Bridget's ward are made to the POLL consultant psychiatrist. Referrals come from the community, GPs, the admission unit, day care centre and from nursing homes.

**PROCESS OF ADMISSION**

There is an admission policy available on the ward. Admissions are always planned. All referrals are assessed by the POLL consultant psychiatrist and other team members prior to admission. This may be done through the day care centre and also by domiciliary visits. All admitted patients have a physical examination. Information is given to the family by the nursing staff where appropriate. All admissions are reviewed within 24 hours by the consultant psychiatrist.

**CARE PLAN**

There is no multidisciplinary care planning on this ward. There is a nursing care plan for each patient, outlining goals, problems and interventions. It does not contain a formal risk assessment. The nursing care plan is reviewed every week. The nursing care plan is not specific for elderly care patients. There is a treatment plan for each patient documented in the clinical file.

**NURSING PROCESS**

The nursing model is one devised by the Longford-Westmeath service and is based on the Roper Logan Tierney model. There are general levels of observation throughout the ward. There is no key worker system in operation. Nursing staff are assigned to patient groups to provide nursing care.

**ACCESS TO THERAPY**

Access to a psychologist, social worker or occupational therapist is by referral through the consultant psychiatrist. Team meetings are held weekly on the ward. The NCHD attends the ward daily and the consultant psychiatrist attends at least weekly, but more often if necessary. There is access to radiology and laboratory services. However, patients requiring medical or surgical assessments must attend the A&E department and may often wait several hours to be seen. This is unsatisfactory for elderly confused or mentally ill patients who may need up to two nursing staff to remain with them during this time.

**ACCESS TO THERAPEUTIC PROGRAMMES**

One patient attends the activation unit on the hospital campus. There are music therapy and art therapy sessions provided by the VEC available on a weekly basis on the ward. The occupational therapist provides reminiscence therapy. Up to recently there was massage therapy provided on the ward.

**CLINICAL RISK MANAGEMENT**

Policies on the management of violent episodes, on searching patients and their belongings, on patients missing from the unit and on restraint were all available. Seclusion was not carried out on the ward. Buxton chairs and restraining belts were used for the purposes of patient safety and to prevent patients falling. This was documented in patients' files by the consultant psychiatrist but was not recorded in a register of restraint. There was no nursing record of restraint and length of time for restraint was not specified. There was no formal clinical risk assessment in the clinical file. Some staff on the ward had not

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received training in manual lifting, cardio-pulmonary resuscitation, control and restraint techniques, or breakaway techniques. There was a policy on reporting of serious incidents through a reporting system. The ward staff receive feedback on reported incidents. Serious incidents are reviewed by the clinical team and nurse management.

### UNIT MANAGEMENT

There are no patients transferred in or out of the ward due to bed shortages. There is no waiting list for the ward. The external door to the ward is locked at all times. CCTV is not used in the ward. There are six nursing staff and two household staff on duty during the day. At night there are two or three nursing staff on duty. Nursing staff rostering is done centrally. The NCHD is available for phlebotomy. It was stated that there is sometimes a delay on essential maintenance for the ward. There are open visiting times on the ward and families are actively encouraged to visit. Breakfast is at 0930h, lunch at 1215h and dinner at 1630h. Snacks are available at other times. Bedtimes start at 1730h for the more disabled group of patients. The patients who are more mobile do not go to bed until later.

### SERVICE USER INVOLVEMENT

There were information leaflets for patients, notices of patients' rights, and information on services available and complaints procedures available on the ward. There was information about advocacy services on display. Rights of patients under the 1945 Mental Treatment Act were prominently displayed.

### RECORDS

The patients' clinical files were manageable and tidy. Progress reports were signed and dated and there was an up-to-date treatment plan in the file. Some signatures were illegible and had no staff designation. The nursing records were legible and up to date, with signed and dated entries. The prescriptions on the medication sheets were initialled and not signed, which is unacceptable. No signature banks were available.

### ENVIRONMENT

The ward was clean and pleasantly decorated with many homely features and ornaments. There were two living areas that were bright and cheerful with comfortable chairs and flame-effect fires. All patients were up and sitting in chairs, some of which had attached tables. There was a TV and DVD player. One living area was also a dining area. There was an enclosed large glass veranda that was used as a living area, and an outside area with seats. The sleeping areas consisted of three dormitories and two single rooms, again pleasantly decorated. There was a disabled access shower room and a bathroom with a Parker bath. There were toilet facilities in the dormitory and living area. Some of these areas were in need of re-tiling and decoration. There was a small nursing office and a clinical room.

### ST. CLAIRE'S WARD

*Date of inspection:* 14th June 2005

*Number of beds:* 26 male

### DESCRIPTION

St. Claire's Ward occupies the top floor of a three-storey, stand-alone building in the grounds of St. Loman's Hospital. The age range of the patients is from 45 to 85 years. The ward provides a mix of elderly care, continuing care and respite care. The patients on the ward are all on Voluntary status. The ward is an open ward, with free access to and from the ward.

### REFERRAL

Three consultant psychiatrists admit patients to the ward: the consultant psychiatrist for Psychiatry of Later Life (POLL); the consultant psychiatrist for the Mullingar sector and the consultant psychiatrist with responsibility for St. Edna's Ward.

### PROCESS OF ADMISSION TO THE WARD

There is no agreed admission procedure. Some admissions come through the admission ward and

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others have come from community residences in the service. Four patients have been transferred from St. Edna's Ward. Some of the patients have alcohol problems and several had been unable to cope with living on their own and had had several admissions to hospital before being admitted to St. Claire's Ward.

#### CARE PLAN

There is no multidisciplinary care planning on this ward.

#### NURSING PROCESS

The nursing model used on the ward is the Roper Logan Tierney model. This focuses on activities of daily living and, while it seems to be appropriate for identifying and recording physical needs of patients, it does not adequately address their mental health needs. Goals are set for each patient in response to the identified needs and these goals are reviewed every four weeks. There is no formal risk assessment in use. There is no policy on observation. It was reported that hospital policy is for all staff to wear uniforms and name badges.

#### ACCESS TO THERAPY

There is no rehabilitation team, and no psychologists, occupational therapists or social workers visit the ward. A consultant psychiatrist visits the ward weekly and more often if required. NCHDs visit the ward daily Monday to Friday and are on call at the weekends. Medical and surgical consultations take place at the county hospital and patients are transported there by taxi, accompanied by a staff member. Staff can access laboratory results quickly. A chiropodist visits the ward every six to eight weeks.

#### ACCESS TO THERAPEUTIC PROGRAMMES

There are no organised groups or therapeutic programmes on the ward. One patient works in the hospital stores. Five or six patients attend the patient activity centre during the day.

#### SECLUSION

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

#### CLINICAL RISK MANAGEMENT

There was no policy on clinical risk management available on the ward. Nursing staff use personal attack alarms and a response is organised from the two wards on the lower floor. There are no policies on alcohol and illegal drugs, or on giving medication without consent. There are policies on patients missing from the ward and the management of violent episodes. Serious incidents are recorded and this data is collected for action and for audit purposes. Mechanical restraint is not used on the ward. While staff training programmes are available in the hospital, it was reported that staff on this ward have had little access to training. Pharmaceutical representatives occasionally visit the ward and provide information on medications.

#### UNIT MANAGEMENT

There are no transfers to other units but this ward has been used for sleeping over patients from the admissions ward. The door to the ward is open during the day and locked at night. There is central rostering of staff to the ward. The staff complement is three nurses from 0800h to 1800h and one nurse from 1800h to 0800h. There are two attendants on the ward from 0800h to 1730h. Newspapers, TV, radio and card games are provided on the ward. There is no CCTV and the ward is not used for other purposes. Patients on the ward are not given cash. Instead, they are given chits, which can be used in the hospital canteen or exchanged there for cash. Phlebotomy services are provided by the NCHDs. There is no waiting list for the ward. Visiting times are flexible. Drinks and snacks are provided at set times during the day. Some alcohol is provided to the patients three or four nights per week. Meal times are 0900h, 1200h and 1730h. Meals are self-service from a trolley and there is a choice of food. There are no patients awaiting appropriate discharge placements although it was the opinion of staff that most of the current patient group could function well in a community residence setting.

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### SERVICE USER INVOLVEMENT

Patients are provided with information on treatment and therapies if they request it. There are some information leaflets available. An advocate visits the ward. There is a complaints policy and patients' opinions are sought on an informal basis. There is no community meeting held on the ward.

### ENVIRONMENT

St. Claire's ward can be accessed by stairs or lift. The ward was drab and in need of refurbishment and painting, and the facilities available were very basic. There was only one shower for 26 patients and there was no bathroom. Sleeping accommodation was in two large dormitory areas, which had curtains around the beds but provided little or no privacy. Patients had their own wardrobes and storage space but these were not big enough and they were not lockable. Some of the patients had large chains and padlocks around their wardrobes.

The nursing office was small and the nursing staff had a small room for their own use, but did not have access to shower facilities. There was no other office area on the ward. A clinical room had a range of medical supplies, and cardio-pulmonary resuscitation equipment, oxygen, suction and clinical waste bin were available. There was a small smoking room and a large lounge at the entrance to the ward. The dining area was large enough to accommodate all the patients. There was no quiet room available to patients and there was no information board. Some of the toilet areas had been renovated but one toilet area had no urinals and this seemed to be a constant source of problems.

### RECORDS

The patients' charts were tidy and manageable. The front cover contained the patients' name and hospital ID. Entries were all dated and signed but not all signatures were legible, nor were staff designations always used. The clinical file contained treatment plans, progress reports and consultant reviews. NCHD entries were more frequent, though some patients had not been reviewed by a doctor for several months. The nursing notes were signed, dated and

legible but full names and designations were not always used. The weight of patients was recorded on a monthly basis. The files inspected contained no entries from social workers, occupational therapists or psychologists. No signature bank was available. A card index system was used for medication. The combined prescription and administration sheets were signed and dated but some of the signatures were not readily identifiable. The generic names of drugs were used. Discontinuation of medication was not always signed and dated.

### ST EDNA'S WARD

*Date of inspection:* 14th June 2005

*Number of beds:* 18

### DESCRIPTION

St. Edna's ward is described as a locked unit for male patients with serious behavioural problems. On the day of inspection there were 18 patients; six were on Temporary status and one was a Person of Unsound Mind (PUM). Bed numbers in the ward have been reduced from 22 to 18 in the past two years.

### REFERRAL

The source of referral for St. Edna's Ward is the admission unit within St. Loman's Hospital. The consultant psychiatrist makes the decision to transfer patients to St. Edna's Ward.

### PROCESS OF ADMISSION

There are no children under 16 year of age admitted, but there are people with moderate intellectual disability in the ward. Patients are not admitted for detoxification although such admissions had happened in the past. There are no admissions for social crises.

The physical and mental health assessment on admission is done by the NCHD who examines the patient on the admission unit and carries out a further assessment on St. Edna's Ward. A collateral history is usually taken when the patient is admitted

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to the Admission unit, however this may be done on St. Edna's Ward if needed. There is no communication with the patients' GPs but their next of kin is informed. The consultant psychiatrist reviews the patient's care within 24 hours of transfer and the initial treatment plan is documented in the file.

There is a policy on nursing patients in night attire, although this is used intermittently on this ward. It was stated that if the staff are familiar with patients they are not placed in night attire. Generally on admission patients are placed on one-to-one observation. In the key worker system operating on this ward, nurses are allocated to groups of patients on each shift.

#### CARE PLAN

The care plans on this ward are nursing care plans which are accessed by the medical and nursing staff and which identify goals and objectives. These care plans are reviewed on a three-monthly basis. The patient is involved in the care planning process through one-to-one meetings with the key worker. There is no documented evidence of carer involvement in care plans although the Inspectorate was informed that there is regular contact with visitors when they come to the ward.

There is a planned process for discharge from this ward. Some patients return to the community or are discharged to high support hostels. A period of leave takes place prior to discharge and the ward staff engage with GPs, family members and community teams.

#### NURSING PROCESS

There are no nursing models identified on this ward although staff said that the current system originated from Roy's model of nursing. It was reported that the current system is appropriate to the needs of the patient group and that there is a formal process of risk assessment. Patients are rarely on any observation level other than general observation due to the philosophy of the ward, where patients as much space as possible. As it is a locked ward, all levels of potential aggression or violence are contained within the ward. The staff are identified by name badges.

#### ACCESS TO THERAPY

Patients requiring psychology, occupational therapy or social work input are referred by the consultant psychiatrist. None of these disciplines are part of a core team on the ward. An art therapist and a literacy teacher attend the ward. There is one consultant psychiatrist who reviews the patients on a regular basis and there is daily contact with the NCHD, who carries out any physical interventions and refers to A&E if necessary. X-rays and laboratory tests are performed in the county hospital.

#### ACCESS TO THERAPEUTIC PROGRAMMES

There is an in-house programme on the ward addressing specific projects. Patients can access rug-making, music groups, a cinema club, walks in the grounds, art, a garden project, recovery group, gym and literacy class. Apart from the arts and literacy class, these groups are run by nursing staff.

#### SECLUSION

There was a seclusion policy in place on this ward and an up-to-date register. Seclusion facilities were situated in a central corridor of the ward. The seclusion room was generally clean and appeared to be a safe environment. The bed was fixed to the floor and the mattress cover contained a zip, which could be hazardous. The walls were rounded and there were no rough edges in evidence. The windows were covered with plastic glass sheeting. It was ventilated and well lit. There was access to a toilet next door to the seclusion room. There was an observation panel in the door and the patient was able to communicate through this. The door opened outwards and was solid and of adequate width. However it was noted there was only one lock on the door and this appeared to be somewhat flimsy. Refractory clothing was not used and the patient was dressed in pyjamas when in seclusion. CCTV was used in the seclusion area and there are 15-minute checks on the patient. There was a seclusion policy and the register was up to date. The Inspectorate was informed that this facility was rarely used and the seclusion register verified this.

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### CLINICAL RISK MANAGEMENT

There is a comprehensive risk management policy based on clinical risk assessment. There is an alarm system in operation which is tested on a weekly basis. There are policies regarding the illegal use of drugs and alcohol and patients absent without leave from the ward. There is a comprehensive policy on the management of violent episodes and the consultant psychiatrist prescribes medication to be used if rapid tranquillisation is required. The procedure for giving medication without consent is in consultation with the doctor wherever possible, and assistance is obtained from other wards within the hospital. There is a comprehensive HSE policy on consent. It was stated that on this ward it was not appropriate to search a patient or any of their belongings.

No mechanical restraint is used. The procedure for physical restraint is to bring as many staff in the ward as possible to assist, but there does not appear to be any structured approach to physical restraint. Any restraint is documented on incident forms and within the nursing notes.

There is no formal training in any restraint techniques, or in de-escalation or breakaway techniques. There is regular training for cardio-pulmonary resuscitation and pharmaceutical representatives carry out sessions on medication used in mental health. The CNM2 on the ward is a trained critical incident de-briefer and there is access to a preceptorship course.

Although it was apparent that the nursing staff knew the patients very well there did not seem to be any formal risk assessment process in place. Serious incidents are reported on incident forms and these are audited and filled out by the risk management department.

### UNIT MANAGEMENT

Patients on this ward are not transferred to other wards within the hospital. The ward is always locked and there is extensive use of CCTV. As well as in the seclusion room, there is CCTV on the external doors, one of the bedrooms, the dining area, the day room and the main corridor of the ward.

There are five nursing staff on duty during the day and two at night. The staff are rostered from the administration office but there is a core group of staff who work regularly on this ward. There are two household staff. New staff are inducted to the ward, following a process of orientation regarding the layout of the ward and a very detailed patient handover.

There is no available ward clerk and the NCHD performs venepuncture as required. It may be difficult to discharge patients due to lack of facilities in the community and patient risk factors. This ward has recently undergone refurbishment since the last inspection. The general standard was very good with regards to décor and layout of the ward. A new kitchen has been installed which is modern and meets the needs of the ward. The dining area is pleasant and there are areas set aside for visitors. Visiting times are flexible. The meal times are set and there is availability of drinks and snacks between meals.

### SERVICE USER INVOLVEMENT

There is information available on treatment, therapies and patients' rights, clearly displayed in the main corridor of the ward. There is a complaints policy and complaints are followed up by nursing administration. Staff stated that they obtain patients' views through informal meetings. There is also a suggestion box in the visiting area for people to make comments if they wish. There is regular access to the Irish Advocacy Network.

### RECORDS

Patients' names and numbers were identified on all pages and the notes were legible. However they were extremely untidy, there were a number of loose pages, and there did not appear to be any structured order to the case notes. Entries had full name and designation of personnel and they were signed and dated. There were no progress reports from other health professionals. There are treatment plans contained within the files and these are dated and signed on a regular basis. The consultant psychiatrist reviews the patients weekly and the NCHD calls to the ward daily.

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The nursing notes were clear and legible. The patient's name was on each page and these notes were tidy. All interventions were signed and dated.

The medication card index had only space for the prescribing doctor's initials and for the nurse to record the administration.

## ENVIRONMENT

This was an 18-bed male locked ward situated in the grounds of St. Loman's Hospital, Mullingar. This ward had recently been refurbished and it appears to be well maintained. There was disabled access and the ward was on the ground floor. There was adequate lighting and ventilation and the décor had been recently painted. The corridors in the ward were long, wide and appropriately furnished. There were numerous information boards with plenty of relevant information contained on them. There was a code of conduct displayed.

There was a designated visitors area which was nicely furnished and of good size. There was access to a garden area at the front of the ward. The bedroom areas had recently undergone refurbishment and as a result there were no curtains around the beds but there were curtains and rails in the ward ready to be fitted. There were eight single bedrooms which, although small, were well maintained and patients had personal belongings in these rooms. The rooms were not locked at night. The dormitory areas were pleasantly laid out and there were four beds in one dormitory and six in another. Patients had their own individual wardrobe spaces and the décor was of good standard.

The toilets and bathrooms were of a reasonable standard. There was free access to the toilet, and the bathrooms had to be locked due to patient risk factors. All the bathroom doors had overriding locks.

The dining area was a very pleasant environment. It was suitable for all patients at one sitting. There was self-service and normal crockery and knives and forks were used. The décor in this room was excellent. There was a dedicated exercise room that had fully equipped gym equipment and was regularly used by the patient group.

The lounge area was comfortable and appropriately furnished. The furniture was not the usual hospital standard issue and the chairs were comfortable. Patients had access to a daily newspaper, magazines and some had made their own specific orders with the local newsagent. There was also a weekly local paper delivered. There was access to TV, video, radio and books and the décor of this room was excellent. There was also a quiet area with comfortable seating and books available and the décor was good.

The nurses' station was situated centrally within the ward. It appeared to be suitable for confidentiality and there was reasonable space for report writing. It was accessible to the patients. There was a phone system in place but no IT and there was an alarm system.

The clinical room was situated in the area designated for sleeping although there were plans to move this to a more accessible area. It contained all the necessary equipment and drug storage. There was a dedicated staff area on the ward that contained a changing room, toilet and showers.

There appeared to be adequate storage on this ward for the patients' possessions. Files and records were stored appropriately and medication was locked in cupboards in a trolley.

## STAFF TRAINING

Training is available for nursing staff on this ward and as with the Male Admission unit the training record is kept by nursing administration.

## ST. MARIE GORETTI WARD

*Date of inspection:* 14th June 2005

*Number of beds:* 25 male

## DESCRIPTION

This is a locked first-floor ward for the care of elderly patients and particularly those with increased needs due to physical infirmity. It provides acute and respite care along with continuing care for those with physical illness as well as psychiatric illness. There were six detained patients on the day of inspection.

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### REFERRAL

Although not established as an acute ward, this ward has begun to take direct admissions to avoid elderly patients being admitted to the general acute ward. There are no acute beds for Psychiatry of Later Life (POLL) in the service. In addition some patients are admitted directly for respite care. Other patients are admitted through the male admission ward. Most patients have a domiciliary assessment first, prior to admission to this ward.

### PROCESS OF ADMISSION

There is no formal admission policy for this ward although there is a policy for the admission ward in the hospital. It is not considered appropriate to admit patients with moderate intellectual disability to this service. There was one patient in the ward at the time of inspection awaiting placement in the learning disability services. There are occasional admissions for detoxification. Admissions for social crisis are discouraged. Generally, all patients are assessed at home prior to admission by the POLL consultant. There is a community mental health nurse on the team. Physical examinations are performed on admission by the NCHD. The consultant psychiatrist for the ward makes the admission to admit a patient together with the patient's GP and family. The treatment plan is also decided prior to admission. Patients generally wear day clothes from the time of admission.

### CARE PLAN

There is no multidisciplinary team available on the ward. The occupational therapy staff of the EALA Activity Centre provide a session one hour a week on the ward and there is an identified need for more sessions. There is no social worker or psychologist available to the ward. Patients can be referred to the psychologist for assessment. In addition to review by the consultant on the ward, patients are reviewed at the sector meetings, which are held in the day hospital nearby. The nursing staff from the ward do not attend these meetings. There is documented evidence of family or carer involvement in the care plan. The discharge process was conducted solely through the consultant psychiatrist. There is a team meeting every week.

### NURSING PROCESS

The nursing model in use is an adaptation of the Roper Logan Tierney model which had been introduced in the previous month. It is described as "nursing care plan implementation and evaluation". The nursing care plan is reviewed every three months for long-stay patients. The CNM2 is responsible for ensuring that all care plans are reviewed. The care plan does not contain a formal clinical risk assessment although it does contain a section on maintaining a safe environment. All the staff wear name badges. There is an observation policy for this service but no patient on this ward requires special observation or close observation. There was no key worker system in operation at the time of inspection.

### ACCESS TO THERAPY

There is access to one hour of occupational therapy a week. There is no access to social worker, psychologist or counsellors. The consultant attends the ward at a minimum of once a week and also as required and there is a regular review of recently admitted patients. The NCHD attends the ward each day. Patients attend the local general hospital for their medical and surgical consultations, which may involve long delays. The staff are quite satisfied with access to laboratory and X-ray results.

### ACCESS TO THERAPEUTIC PROGRAMMES

It was reported that none of the patients on the ward attends the EALA Activity Centre. One patient goes to the day hospital twice a week. Most patients are not able to leave the ward and there is very little evidence of any needs-based therapy. There is one group conducted on the ward by the occupational therapist and when staff have time they accompany patients on walks.

It has subsequently been reported to the Inspectorate that patients from the ward attend art and music sessions in St. Bridget's Ward and that any patient who is mobile may attend the EALA centre for structured activities.

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#### ECT

All documentation relating to ECT is kept in the general hospital where ECT is administered although there is a record of the ECT given kept in the individual's case notes.

#### SECLUSION

No seclusion is used.

#### CLINICAL RISK MANAGEMENT

The Department of Health and Children care risk management documentation was available. There is an alarm system in use on this ward. The hospital policy for alcohol and illegal drugs, on patients absconding and the policy on managing violent episodes applies. There is no policy on rapid tranquillisation. There is a clear policy on searching patients' belongings and searching their rooms or bed areas. Buxton chairs are not used for restraint but for safety reasons. Orders for use of Buxton chairs are documented by the consultant in the clinical files. Physical restraint is not used. The staff on this ward have not received training in control and restraint, de-escalation or breakaway techniques. The staff felt that due to difficulties in maintaining staffing levels it was difficult to access training programmes. Incident forms are used to document and investigate serious clinical incidents and near miss incidents and these are audited by the healthcare risk management section, which also arranges debriefing. All the relevant documentation is sent to the catchment team, which reviews incidents and investigates if required.

#### UNIT MANAGEMENT

Patients are not transferred to other units for any reason. There is no waiting list and all referrals are managed by the consultant psychiatrist. The ward is locked. There are five nursing staff on duty during the day and two at night and there is a central rostering system. There are two household staff on during the day. Male staff wear white coats when changing patients but otherwise wear their own clothes. Female staff wear a uniform. There is no

ward clerk available. The NCHD provides the phlebotomy service. Storage in the ward appeared to be reasonably satisfactory. There was no petty cash kept on the ward; there was a chit system in operation for use by patients in the hospital shop. Files and records were kept in the nurses' office and medication was kept in the clinical room. Catering operated on a cook-chill system. Availability of maintenance support is variable. A requisitioning system is in operation. The bathroom has been out of action since the kitchen was upgraded. There were two attendants on the ward from 0830h to 1730h.

Visiting times are flexible. There is no separate visiting area and there is no policy on visitors. Snacks and drinks were freely available on request. Meal times are at 0930h, 1230h and 1630h.

#### SERVICE USER INVOLVEMENT

Information on treatment and therapy is usually obtained through discussion with the doctor. Information leaflets are available on the ward. There is a service-wide complaints policy and there is a complaints /suggestion box. There are no ward community meetings with the patients. At the time of inspection, there was no formal advocacy service to the ward. There is no private visiting area.

#### RECORDS

There is no evidence in the clinical files that patients are seen regularly by the NCHD unless a medical need arises. There does not seem to be a regular psychiatric review by the NCHD. On inspection of the clinical files, the physical examination by the NCHD on admission was not dated. The ICD/DSM diagnosis was not on the front sheet or in the chart. Entries were dated and signed and a designation given by the consultant psychiatrist, but not by other members of the team. The nursing care plan was the only care plan in use. The medication prescriptions were legible and were dated. Generic names were not used, but the dose was clearly written as were the intervals and this was signed by the doctor. The name of the doctor was initialled only on the prescription sheet. Documentation on the administration sheet was legible. Refusal of medication was noted and discontinuation of medication was not signed though

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it was dated. Nursing notes were satisfactory and in general the name was legible.

### ENVIRONMENT

The ward was located on the first floor. It was clean but the décor was drab and bare with minimal furnishings. The entire ward needed to be refurbished. There was a need for more comfortable chairs although some attempts had been made to get more soft furnishings. There was a marked absence of privacy. Entry to the ward gave immediately onto the day room, which had some comfortable furnishing and a TV, though more chairs were required. There was a smoking room, which also contained a TV. The main day room led into the dining and day living space. Patients requiring more care were based in this area. It too needed more soft furnishings. The kitchen had been upgraded recently but this had involved decommissioning a bathroom area and this had not been restored. This meant that there was only one shower for the entire ward, based at the very back of the ward. There was mildew in the shower room and it needed an extractor fan. There was no bath available in the ward nor was there a sluice room. The toilets that were in use lacked seats and needed to be refurbished. There were no rails around the toilets. The toilets and bathrooms were of very poor standard. There was free access to the daytime toilets. There were no en-suites on the ward. There was a rota system in operation regarding showers with approximately four having a shower per day. All patients required assistance in showering.

There was one bedroom with ten beds, one bedroom with eleven beds and one room with three beds. There were two single rooms, one of which was used for storage. There were individual wardrobes but very few personal belongings evident. The radiators were built into the walls which meant that the staff had no control over them. The boiler system controlled the heating system for three wards and this meant that the ward could be extremely hot when the weather was warm and very cold when it was cold outside.

The lighting was adequate. There was only one short corridor in the ward and this was of adequate width. There were information boards and a suggestion box on the ward. There was no clear defined reception

area or admission area. In the dining room there was adequate space for all at one sitting. There was no choice of menu. The room was bright and doubled up as the day room. There were no exercise activities available on the ward. The lounge area had some comfortable seating although more was required. Newspapers were delivered every day. Phlebotomy and urinalysis were carried out in the clinical room but there was no examination couch. The emergency trolley was located in the clinical room. The nurses' station was centrally located however there was no facility for observation. There was confidential space for report writing. There was one staff room used for changing and also a tea room. There was a unisex toilet available for staff but no showers.

### STAFF TRAINING

Staff reported that training is available but it is difficult to access and often must be done in their own time.

## LONGFORD-WESTMEATH

### ASHFORD HOUSE, LONGFORD

*Date of inspection:* 15th June 2005

*Number of beds:* 14 beds

### DESCRIPTION

Ashford House opened in 1991 and is a 14-bed residence with 24-hour nursing staff supervision approximately two miles from the town of Longford. There are currently eight male residents and six female residents and there is one respite bed.

### REFERRAL

Referrals to this residence come from St. Loman's Hospital in Mullingar. All referrals to the residence are made to the consultant psychiatrist who has clinical responsibility for the residence. The referrals are assessed by the consultant psychiatrist and NCHD, and discussed at the team meeting. However the nursing staff of the residence are not involved in the assessment of, or decision to transfer a patient to the residence.

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#### PROCESS OF ADMISSION

There is an admission policy in existence. Residents are admitted to support their ability to maintain a life in the community with high levels of supervision and to continue rehabilitation to facilitate a move to more independent accommodation. The residence is not used as an alternative to an acute admission. There is a respite bed available and this is mainly used for people who are in lower support hostels and require respite care. There are no admissions to this residence for the purpose of detoxification. Residents may be admitted for social reasons.

On admission, residents are familiarised with the residence, house rules, routine, staff and other residents. An initial care plan is implemented and all benefits and social welfare are arranged. All residents are registered with the local GP and a collateral history is obtained from family and carers, if not already available. Family members can visit the residence prior to transfer. The consultant psychiatrist usually reviews the resident within a week of the transfer. The initial treatment plan is nurse led and is documented in the nursing notes. There is a key worker system and the resident is allocated a key worker on admission.

#### CARE PLAN

The system of care planning is currently being reviewed within the HSE Midland Area. An audit has recently been undertaken by the Practice Development Department and there was a comprehensive audit report available in the residence. The staff are keen to have a care planning system in place within the residence but are uncertain of the procedures for implementing system. At present, the nursing staff carry out a comprehensive needs assessment, including a life skills profile. There was formerly occupational therapy input into the assessment process but the occupational therapist post is currently vacant. Residents are encouraged to sign the care plan and each resident has a key worker. The current care plans contain goals and objectives but the progress notes do not pertain to the care plan and the care plans are stored separately from the progress notes. On occasion, carers and family members have been involved in the care planning process. The discharge plan process is also

part of the review, however there are few discharges from this residence; there were no discharges last year and one person returned to hospital. There is currently one resident being considered for a lower level of support. There is regular contact by the nursing staff with GPs and family members and the community team.

#### NURSING PROCESS

The nursing model is an eclectic model which was varied in its sources. The model is appropriate to the needs of the residents and all staff are familiar with the care plans. However staff were not clear on how to write the interventions pertaining to the care plan. There is minimal risk assessment carried out on each of the residents.

#### REHABILITATION TEAM

There is no multidisciplinary rehabilitation team with responsibility for this residence. There is psychology input through a referral system, and there had been occupational therapy groups and programmes in the residence. However the occupational therapy post is currently vacant. There is no social work contact; all social welfare and housing needs are undertaken by nursing staff. There is a consultant psychiatrist responsible for the residence and there is regular contact with the NCHD. The Inspectorate was informed that the consultant reviews each resident every three weeks. This was not backed up by written evidence in the clinical file. There were some residents who had no written interventions in their clinical files for a number of months. The residence also has access to a dietician and chiropodist, and the residents have access to a local dentist.

#### INVOLVEMENT IN REHABILITATION PROGRAMMES

All the residents have identified programmes and care plans. The philosophy of the residence is to promote independence and increase living skills within a reasonable time frame. Residents can attend day services off site and there is a day centre nearby. There is also access to employment training programmes. Residents attend meetings facilitated by

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GROW. Although some residents can leave the residence unaccompanied it is usual for nursing staff to accompany them.

### CLINICAL RISK MANAGEMENT

There is a policy on risk management available. There is no alarm system and this is not deemed to be necessary. There are policies surrounding the use of alcohol and illegal drugs within the residence and on residents missing. The only time any room was searched was if any money was missing. There is no clinical risk assessment document in residents' files. The method of reporting serious untoward incidents is the same as in the hospital.

### UNIT MANAGEMENT

There are no temporary or long-term transfers to other units. There are two nursing staff on duty in the morning with one on the late shift. There are two attendants during the day and there are two nurses at night. The attendants carry out the cooking and cleaning duties within the residence. There is consistency of staff in the residence although they are supplemented by a central rostering system to cover holidays and sickness. There is a formal process of induction for staff. This involves an orientation to the building, house rules, and, for staff, knowledge of the residents. The staff have a smart casual dress code and they wear name badges within the residence but not when they are accompanying a resident in the community. An annual report is compiled on bed statistics, discharges and admissions to the residence. There are policies and procedures in place. There is no structured feedback or resident satisfaction measurement in place. The waiting list for the residence is managed by the consultant psychiatrist and the HSE are responsible for the maintenance of the building. It was reported that there are a number of residents in hostels in the area who require nursing home accommodation but there are difficulties in accessing this. A working group has been established to try and overcome this problem.

### HOUSE RULES

There are house rules in place which are implemented by the staff. The rules prohibit use of alcohol or illegal drugs within the residence but residents may go to the pub. Other rules concern respect for other people's personal space, working with other residents, smoking in designated smoking areas only and treating the staff and building with respect. Visiting times are flexible; relatives and friends can visit at any time they wish. The residents do not have a front door key and they can lock the bathroom door although they are not encouraged to lock the bedroom doors. Residents are allowed to leave the residence unsupervised if well enough. Residents inform staff if they leave the residence and indicate their expected time of return. Residents have the choice of staying in the residence during the day.

Meals are prepared by the attendants on site. Residents are involved in the menu planning and the ordering of the shopping, which is delivered by a local shop. Residents have free access to the kitchen to make drinks and snacks. They are not required to go to bed or get up at set times. There are a number of shared rooms and the staff decide which residents share bedrooms. Visitors are not allowed to stay overnight. Residents have their own clothing and they are encouraged to go to the local shops to buy their own clothes, some with the assistance of staff. Some of the residents manage their own finances. All have post office accounts and have free access to their accounts. Any withdrawals or payments into their accounts are monitored by the residence staff and there is a money management policy in place. Some residents have bank cards but not all are able to use them independently. Money for housekeeping money is taken from the residents and this is signed for by the resident and staff. All residents are in receipt of all the benefits they are entitled to. The HSE provide all the furniture and fittings within the residence. However residents can obtain individual pieces of furniture for their own use if they so desire. There is a washing machine and tumble dryer within the residence and these can be used with the supervision of staff. Some residents access services in the community unaccompanied, though some need to be accompanied by nursing staff. There is a range of activities available such as visiting local shops, pubs and cafés. There is a regular bowling group, people go to the theatre, have holidays and go to the library. Most of the local facilities are within walking distance

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and there is transport available to the residence. A number of the residents use taxis, which they pay for themselves.

#### SERVICE USER INVOLVEMENT

There is information on treatment and therapies available as well as information on rights. All the residents have the right to vote and do so. There is information available on national health initiatives. There is a complaints policy within the HSE Area but there is no local complaints procedure within the residence. Residents' opinions are sought at planning meetings. This tends to be around menu planning and identifying where people wish to go on holiday or what activities are available. There is no formal process for obtaining carers' or family members' opinions although they have the opportunity to talk to staff when they visit the residence. There is access to the Irish Advocacy Network on request.

#### RECORDS

Residents cannot access their files and therefore do not write in them. The files were of a reasonable standard although some contained a number of loose pages. Entries had full name and designation of the staff and were dated and signed. In some files there were progress reports but in others this was lacking. There were no progress reports from other health professionals. Some files contained a treatment plan but the majority did not. As stated earlier, some files had no written evidence of regular consultant psychiatrist review of residents.

Nursing files were extremely neat and tidy and had entries signed and dated. As stated earlier, the care plans were clear but the progress notes did not pertain to the care plans.

The medication charts were signed and dated and were legible. However there were no residents on a self-medication programme.

#### ENVIRONMENT

There was a regular ongoing maintenance programme in place but there were some difficulties

accessing this. The residence was clean and had a good standard of decor. It appeared to be comfortable but there was limited privacy in the shared bedrooms. It appeared to be a safe environment although as stated earlier the residents did not lock their bedrooms at night. There was space for personal storage. The residence contained two lounges and a smoking lounge, two dining areas, a kitchen, laundry area, clinic room, two staff offices, bathrooms and toilets which were gender specific, three single bedrooms, and six double bedrooms. There was garden access.

#### STAFF TRAINING

There is training available based at the Tullamore Nurse Training Education Centre. Some staff have undertaken degree courses and all are encouraged to attend courses wherever possible.

#### EDGEWATER HOUSE, MULLINGAR

*Date of inspection:* 15th June 2005

*Number of beds:* 13 beds

#### DESCRIPTION

Edgewater House is a residence with 24-hour nursing staff supervision on the edge of Mullingar town. The residence was opened in June 1995 and has capacity for 13 residents. On the day of inspection, the single respite bed was vacant. There are currently three male residents and nine female residents. The age range is from 26 to 78 years.

#### REFERRAL

The sector consultant psychiatrist makes all referrals to the residence. All referrals come from St. Loman's Hospital, Mullingar.

#### PROCESS OF ADMISSION

There is no admission policy specific to the residence. All decisions to transfer a patient from St. Loman's Hospital to the residence are made by the consultant

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psychiatrist. Re-admission and exclusion criteria are decided by the sector team, but are not formally documented. All transfers to the residence are for rehabilitation, with one respite bed available – usually filled by a resident from a lower level of supported accommodation. All new residents are visited by nursing staff prior to admission. Families are informed if appropriate. All residents are registered with a GP. Patients' clinical files are located in the outpatients department and residents continue to attend outpatients. The consultant psychiatrist visits the residence only on request.

### CARE PLAN

There is a nursing care plan in place. There is limited multidisciplinary input into this residence and therefore there is no multidisciplinary care plan. The medical treatment plan is documented in the medical notes. These notes are stored in outpatients and were not inspected. There is no documented discharge planning process. In 2004, there were no discharges from the residence and it was reported on this inspection that there are five residents waiting lower levels of support.

### NURSING PROCESS

The nursing model in use is currently under review as it is not appropriate to a rehabilitation service. There is a key nurse system in place.

### REHABILITATION TEAM

There is no dedicated rehabilitation team. The consultant psychiatrist visits the residence on request; residents are reviewed in the outpatients' clinic. Residents access their GP independently. The residence is staffed by nursing and care attendant staff.

### INVOLVEMENT IN REHABILITATION PROGRAMMES

There is no formalised rehabilitation programme that is linked to care planning. Residents are encouraged to be included in daily household tasks and social

outings. Residents are encouraged to attend Ashbrook Activation Centre on a daily basis. One staff nurse also attends the Activation Centre if enough staff are available.

### CLINICAL RISK MANAGEMENT

There is no overall clinical risk management policy for rehabilitation service. There are general HSE Area policies on residents missing. There is no documented individual risk assessment in the nursing file. Auditing and debriefing of clinical incidents are not routinely carried out. Staff are encouraged to attend cardio-pulmonary resuscitation and other mandatory courses on a two-yearly basis. There is no training in rehabilitation. Nursing students attend the residence for two-week placements.

### UNIT MANAGEMENT

The residence is not used for short-term or long-term transfers to alleviate bed shortages in other parts of the service. Residents from other supported residences attend for a daily meal. During the day, there are two staff nurses on split shift, two care attendants and one CNM2 on duty. At night, there is one staff nurse and one care attendant. The staff are rostered across the two residences and the activation unit and the residences are self-staffed, which allows for continuity of care. There is a rehabilitation ethos in the residence. The policies and procedures are general to the HSE area rather than rehabilitation or residence specific. No annual report is compiled. There is no measurement tool in use to gauge residents' or family satisfaction. There is a waiting list for residence accommodation and there were no discharges last year. Maintenance staff can be accessed from St. Loman's Hospital.

### HOUSE RULES

The house rules are designed by staff with no set review date and they are not available in writing. Visiting time is open and family are encouraged to visit or take relatives home or on holiday. Two residents have front door keys. Residents are required to let staff know if they will be out for long periods.

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Residents can lock the bathroom door, but not their bedroom doors. Residents are not required to be out during the day but are encouraged to attend Ashbrook Activation Centre. All meals are prepared on site by care attendant staff with help from some residents. Residents can use the kitchen during the day to prepare hot drinks. There is no smoking in bedrooms and there are no set rules on bedtime. Residents' belongings are not listed. There is no written policy specific to the residence on financial management of residents' monies. At the time of inspection, residents were not in receipt of any written information from the HSE Midland Area regarding refund of monies due from the State. Residents continue to pay €30 per week for housekeeping, but the rent of €20 per week has been stopped. Nine residents have their money managed by nursing staff and three residents independently manage their money. There are limited financial controls in place to protect residents and staff members. Residents buy their own clothing and are encouraged to use the utility room. The residents access the community independently and with staff. All community facilities are within a short walking distance of the residence.

### SERVICE USER INVOLVEMENT

There is no written information in plain English available to residents. Information is provided verbally and on request. Residents have been encouraged to avail of the national health initiative BreastCheck. Community meetings are held twice yearly. There is a complaint box but it is rarely used. Complaints are resolved at a local level if possible.

### RECORDS

There are three note sets for each resident, all located in different locations: residence (nursing notes); outpatients (clinical file); and GP (GP notes). The nursing files were the only files inspected. The nursing notes were up to date and each resident had a file. All of the nursing notes reviewed were merely initialled. There was no designation of personnel recorded. There was no signature bank available. The medication sheets were satisfactory. No residents self-medicate.

### ENVIRONMENT

Edgewater House is a single storey building, where two houses have been knocked into one. This has resulted in long dark corridors in the bedroom areas. The house was last painted five years ago and now required upgrading. There was an internal smoking room located off the kitchen and between the utility and pantry. The utility room was in a very poor state of repair. There was no piped ventilation for the tumble dryer.

There is a mixture of single and triple bedrooms. Single rooms are not always available. Some residents have their own TV and music systems in their rooms. All rooms have a sink. The beds in many of the rooms were very low and the furniture needs to be upgraded. All residents had personal storage space and a new walk-in shower had been installed. The back garden was very well kept and secluded. The living room was bright and overlooked the garden.

### GLENAVON HOUSE, ATHLONE

*Date of inspection:* 15th June 2005

*Number of beds:* 10 integrated: 1 male, 7 female. 1 crisis/respite bed

### DESCRIPTION

Glenavon Community Residence is a residence with 24-hour nursing staff supervision in a two-storey building that was formerly two adjoining houses on an estate approximately five minutes walk from Athlone town centre. The residence opened in 1987.

### REFERRAL

The majority of the current residents are in the residence since its opening and are under the care of the Athlone sector team. Nine beds in the residence are filled on a permanent basis. There is one respite bed, which is normally filled on a planned basis in order to provide respite relief for carers. The most recent admission was in March 2005 under the care of the Psychiatry of Later Life (POLL) team. Admissions to the residence are usually discussed at the sector team meeting and agreed with the consultant psychiatrist. Referrals are considered in

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terms of clinical risk. For instance, a history of violence may exclude someone from a placement in this residence.

### PROCESS OF ADMISSION

The person to be admitted is seen by the consultant prior to their admission to the residence. A person coming for respite care may visit the house beforehand with a carer or relative. An information leaflet on the residential service is given to any prospective residents. The new resident is introduced to the house by a member of nursing staff. Following an initial settling in period, a nursing assessment is carried out.

### CARE PLAN

Staff assess the new resident according to a bio/psycho-social/spiritual model of assessment. This process feeds in to a nursing care plan, which is evaluated in a formal way with residents and updated every six to eight months. The care plan for each resident is discussed at the sector team meeting. Any explicit wishes of the resident are documented but there is no formal involvement of the family or carer in the care plan.

### NURSING PROCESS

The nursing staff use a bio/psycho-social/spiritual model of nursing. There is a key worker system in place with one of the senior nurses in the role of key worker. Separate nursing notes are kept and entries are made on each shift during the 24-hour period. A nurse from the residence attends the sector team meeting. Nurses do not wear name badges as they are known to the residents.

### REHABILITATION TEAM

There is no rehabilitation team in this service. Residents can access social work, occupational therapy or psychology services. Residents are seen by the sector psychiatrist in the residence if necessary and are reviewed every three months. The residents are registered with a local GP.

### INVOLVEMENT IN REHABILITATION PROGRAMMES

According to staff, residents participate in a number of individual needs-based programmes, which include budgeting, socialisation, personal clothing and hygiene. Residents can also participate in gardening and take part in outings. An occupational therapist in the day centre and a nurse, who is an employment officer, also design programmes for, and in conjunction with, the residents.

### UNIT MANAGEMENT

There are no temporary transfers to or from the residence due to bed shortages in other units. The residence is self-staffing. There is one nurse on duty from 0800h to 1630h, one nurse from 1245h to 2115h and one nurse from 2100h to 0815h. There is also one household staff on duty each day. There is no waiting list for the residence.

### ETHOS

The ethos of the residence is to provide a therapeutic environment combined with a homely atmosphere for residents. All policies and procedures available in the residence are common to the service although there is a policy group in the sector, which is looking at operational policies for the residence.

### HOUSE RULES

The rules of the residence are designed by the staff and mainly concern health and safety issues. Residents are called at 0800h for breakfast between 0800h and 0930h. Visitors are asked to try to leave the residence by 2100h and there are no facilities for visitors to stay over. Residents do not have front door keys and are required to check in and out. Some of the residents are allowed to leave the residence unsupervised. Residents have free access to the kitchen to make snacks/drinks. Only one resident is involved in the preparation of meals. Residents, in general, draw up the shopping list and the shopping is then delivered. Residents are encouraged to manage their own money if they are able. Three of the residents are independent in this regard. Staff members are agents for some of the residents and

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accompany others to collect their money. A number of the residents access community services by themselves.

#### SERVICE USER INVOLVEMENT

There is no formal measurement of residents' or their families' satisfaction with the service. There are informal talks with staff about outings and holidays. Residents are given an information leaflet on medications and side effects. There is a notice regarding the right to complain but no suggestion box. No advocate visits the residence.

#### RECORDS

The records of all disciplines involved in the residents' care are kept separately. The medical notes are kept in a wallet-type folder, which is quite unwieldy and which has many loose pages inside. Nursing notes and assessments and care plans are kept in a separate file. The notes of other professionals are kept by the professionals themselves at other locations. All the entries seen were signed and dated but the staff designation was often not included. No signature bank is available. The medication prescription and administration sheets were all signed and dated. In many cases initials were used and these are not readily identifiable in the absence of a signature bank. Generic names of drugs were not always used.

#### ENVIRONMENT

The residence is a two-storey house that was originally two semi-detached houses. All the bedrooms are upstairs and no lift is available. This poses problems for residents with mobility problems. On the day of inspection, the downstairs visitors' room was being used as a bedroom for one such resident. Some of the bedrooms upstairs have a door between them, which is used by staff and residents to access other parts of the house. The décor of the house is adequate and the atmosphere is homely.

#### STAFF TRAINING

There is an ongoing programme of training for the Athlone sector staff. This includes training in suicide awareness, cognitive behavioural therapy, stress management skills, pharmacology, lifting and handling, site-specific safety training, the new Mental Health Act and HealthCare records. A record of this training was made available for inspection

#### ROCKVIEW

*Date of inspection:* 15th June 2005

*Number of beds:* 8

#### DESCRIPTION

Rockview Residence is a residence with 24-hour nursing staff supervision located off the main street in Mullingar town. The residence was opened in 1993 and has eight residents. On the day of inspection, there were six male residents and two female residents. The age range is from 27 to 70 years, with an average age of 53 years. The HSE Midland Area owns the house. The house is under a compulsory purchase order. It is unclear where the residence will be located and there is no set time frame for moving.

#### CLIENT GROUP

The nursing staff describe this residence as "medium support" which reflects the fact that the residents are expected to be involved more in the management of the house including meals, shopping and cleaning. There are no care attendant staff in place. Nursing staff are present over 24 hours and are on call to the low support houses. As in the Edgewater residence, a number of residents from low support attend on a daily basis for a main meal for which they pay.

#### REFERRAL

The sector consultant psychiatrist makes all referrals to the residence. All referrals come from St. Loman's Hospital, Mullingar.

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### PROCESS OF ADMISSION

There is no admission policy specific to the residence. All decisions to transfer a patient from St. Loman's Hospital to the residence are made by the consultant psychiatrist. Re-admission and exclusion criteria are decided by the sector team, but are not formally documented. All transfers to the residence are for rehabilitation. All new residents are visited by nursing staff prior to admission. Families are informed if appropriate. All residents are registered with a GP. Patients' clinical files are located in the outpatients department and residents continue to attend outpatients.

### CARE PLAN

There is a nursing care plan in place. There is limited multidisciplinary input into this residence and therefore there is no multidisciplinary care plan. The medical treatment plan is documented in the medical notes. These notes are stored in outpatients and were not inspected. There were two discharges in 2004 from Rockview. One person was discharged to low supported accommodation and one person to elderly care ward in St. Loman's Hospital.

### NURSING PROCESS

The nursing model in use is currently under review as it is not appropriate to a rehabilitation service. There is a key nurse system in place.

### REHABILITATION TEAM

There is no dedicated rehabilitation team. The consultant psychiatrist visits the residence on request; residents are reviewed in the outpatients' clinic. Residents access their GP independently. The residence is staffed solely by nursing staff.

### INVOLVEMENT IN REHABILITATION PROGRAMMES

There is no formalised rehabilitation programme that is linked to care planning. Residents are encouraged to participate in daily household tasks and social

outings. Residents are encouraged to attend Ashbrook Activation Centre on a daily basis.

### CLINICAL RISK MANAGEMENT

There is no overall clinical risk management policy for rehabilitation service. There are general HSE Area policies on residents missing. There is no documented individual risk assessment in the nursing file. Auditing and debriefing of clinical incidents are not routinely carried out. Staff are encouraged to attend cardio-pulmonary resuscitation and other mandatory courses on a two-yearly basis. There is no training in rehabilitation. Nursing students attend the residence for two-week placements.

### UNIT MANAGEMENT

The residence is not used for short-term or long-term transfers to alleviate bed shortages in other parts of the service. Residents from other supported residences attend for a daily meal. At night there is one staff nurse on duty and he or she is also on call to the low support hostel. The staff are rostered across the two residences (Edgewater and Rockview) and the activation unit. There is a rehabilitation ethos in the residence. The policies and procedures are general to the HSE area rather than rehabilitation or residence-specific. No annual report is compiled. There is no measurement tool in use to gauge residents' or family satisfaction. Maintenance staff can be accessed from St. Loman's Hospital.

### HOUSE RULES

The house rules are designed by staff with no set review date and they are not available in writing. Visiting time is open and family are encouraged to visit or take relatives home or on holiday. Residents are required to let staff know if they will be out for long periods. Residents can lock the bathroom door, but not bedroom doors. All meals are prepared on site by care attendant staff with help from some residents. Residents can use the kitchen during the day to prepare hot drinks. There is no smoking in bedrooms and there are no set rules on bedtime. Residents' belongings are not listed. There is no

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written policy specific to the residence on financial management of residents' monies. At the time of inspection residents were not in receipt of any written information from the HSE Midland Area regarding refund of monies due from the State. Residents continue to pay €30 per week for housekeeping but the rent of €20 per week has been stopped. Residents buy their own clothing and are encouraged to use the utility room. The residents access the community independently and with staff. All community facilities are within a short walking distance of the residence.

independently. There was a small internal smoking room with direct access to the garden.

### SERVICE USER INVOLVEMENT

There is no written information in plain English available to residents. Information is provided verbally and on request. Residents have been encouraged to avail of the national health initiative BreastCheck. Community meetings are held twice yearly. There is a complaint box and complaints are resolved at a local level if possible.

### RECORDS

There is three note sets for each resident, all located in different locations: residence (nursing notes); outpatients (clinical file); and GP (GP notes). The nursing files were the only files inspected. The nursing notes were up to date and each resident had a file. All of the nursing notes reviewed were merely initialled. There was no designation of personnel recorded. There was no signature bank available. There is one resident in Rockview who is self-medicating. Medications are dispensed into a blister pack. The medication sheets were satisfactory.

### ENVIRONMENT

Rockview is a large bungalow located in the town of Mullingar. The house was bright, had been recently painted and was comfortable. There was access to a walk-in shower and all bedrooms had a sink. There are three single rooms, one double room and one triple room. Residents had enough storage space and a number of residents had purchased their own furniture. Residents were using the utility room

Laois/Offaly, Longford and Westmeath

## LAOIS-OFFALY RECOMMENDATIONS

### DEPARTMENT OF PSYCHIATRY, PORTLAOISE

1. Each patient should have an individualised care plan that contains a social, psychological, occupational, nursing and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated by the patient's key worker.
2. Members of the multidisciplinary teams should attend multidisciplinary team meetings on the unit.
3. All written interventions and prescriptions must be dated and have a legible signature with the name and designation of the clinician clearly printed. Discontinuation of medication should be signed and dated.

### ST. FINTAN'S HOSPITAL, PORTLAOISE

1. There should be a full multidisciplinary rehabilitation team with responsibility for the remaining patients in the hospital.

### REHABILITATION WARD

1. Alternative accommodation should be found as this ward is unsuitable as a rehabilitation unit.
2. There should be an admission policy for the rehabilitation ward.
3. There should be needs-based activities available for patients that are linked to patients' individual care plans.

4. Essential maintenance and redecoration should be carried out as a matter of urgency.

### MALE WARD 6

1. Each patient should have an individualised care plan that contains a social, psychological, occupational, nursing and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated by the patient's key worker.
2. There should be a restraint policy available on the ward.
3. The poor condition of the clinical files should be addressed.
4. The nursing care plans should be reviewed on a regular basis and kept up to date.

## COMMUNITY RECOMMENDATIONS

### PSYCHIATRY OF LATER LIFE

1. The vacant psychology post in the Psychiatry of Later Life team should be filled as soon as possible.
2. In order to offer a comprehensive day service the day hospital and team headquarters should move to a purpose-built unit of suitable size.

## LONGFORD-WESTMEATH RECOMMENDATIONS

### ST. LOMAN'S HOSPITAL, MULLINGAR

#### OVERALL RECOMMENDATIONS

1. Each patient should have an individualised care plan that contains a social, psychological, occupational, nursing and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated by the patient's key worker.
2. There should be regular multidisciplinary meetings on the ward.
3. There should be a full multidisciplinary rehabilitation team with responsibility for the long-stay wards in St. Loman's ward.
4. Each patient should be assessed as regards their future accommodation in anticipation of the closure of the hospital.
5. There should be no further admissions of patients to long-stay wards.
6. All written interventions and prescriptions must be dated and have a legible signature with the name and designation of the clinician clearly printed.

#### ADMISSION WARDS

1. Each patient should have an individualised care plan that contains a social, psychological, occupational, nursing and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by

appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated by the patient's key worker.

2. There should be needs-based therapeutic activities in the wards for patients who cannot attend activities away from their ward.
3. Patients should not be requested to sleep in other wards due to shortages of beds in the admission units.
4. The poor condition of the clinical files on the male admission ward should be addressed.
5. The nursing office in the male admission ward should immediately be made soundproof to protect patients confidentiality.

#### ST. BRIDGET'S WARD

1. All staff should be trained in manual handling, control and restraint techniques, and cardio-pulmonary resuscitation.

#### ST. CLAIRE'S WARD

2. This ward should close as soon as possible and the patients transferred to accommodation appropriate to their assessed needs. Admissions to this ward should cease.
3. Patients from the acute admission unit should not be transferred to this ward to sleep because of bed shortages.
4. Discontinued medication should be signed and dated.

## Laois/Offaly, Longford and Westmeath

**ST. ANNE'S WARD**

1. The recent needs assessment carried out on the ward should inform the patients' care plans and outline the needs for future accommodation. All staff should be aware of the needs-based assessment and the risk assessment carried out as part of this should be part of patients' care plans.
2. Essential maintenance should be carried out in the interim period before closure of the hospital.

**ST. EDNA'S WARD**

1. Staff should all be trained in restraint techniques, breakaway techniques, and de-escalation.

**ST. MARIE GORETTI WARD**

1. There should be a dedicated unit for acute in-patient treatment in the service for Psychiatry of Later Life.
2. There should be a full multidisciplinary team for the Psychiatry of Later Life service with input into the ward.
3. Each patient should have access to therapeutic activities that are linked to their individual care plan.
4. There should be regular psychiatric and medical review of patients.
5. Appropriate furniture should be provided for patients.
6. The bathroom and hygiene facilities are inadequate for a ward of this size. Appropriate washing facilities must be provided and the existing facilities must be upgraded.
7. Careful control of heating for the elderly population in this ward is essential.

**COMMUNITY RESIDENCES****OVERALL RECOMMENDATIONS**

1. There should be a full multidisciplinary rehabilitation team with responsibility for the community residences.
2. Each resident should have an individualised care plan that contains a social, psychological, occupational, nursing and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the resident and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the resident has been involved in developing his or her care plan, and the resident must have a copy of the care plan. The care plan must be coordinated by the resident's key worker.

**EDGEWATER HOUSE**

1. There should be an admission policy in operation in the residence.
2. The residence requires essential maintenance and redecoration.

**ASHFORD HOUSE**

1. The vacant occupational therapist post that includes input to the residence should be filled as soon as possible.
2. All reviews of residents should be recorded in the clinical file.

**GLENAVON COMMUNITY RESIDENCE**

1. All records pertaining to the resident should be stored in the community residence.

## Chapter 2

Health Service Executive  
Dublin/Kildare

Dublin/Kildare

## AREA 3

### ASHDALE HOUSE

*Date of inspection:* 23rd November 2005

*Number of beds:* 10 integrated

#### DESCRIPTION

Ashdale House is a three-storey community residence close to Terenure village in Dublin. On the day of inspection, there were two male and eight female residents. There are no crisis or respite beds. The age range of patients is between 28 and 71 years and all were former long-stay patients in hospital. The sector teams and the Psychiatry of Later Life (POLL) team have admitting rights and continue to provide a service to the individuals referred to the community residence. The community residence opened in 2000 and it is owned by the HSE, but run by St. Patrick's Hospital. Twenty-four-hour care is provided. The community residence functions as a rehabilitation community residence and as a permanent home for some residents. There is no dedicated rehabilitation team.

#### REFERRAL

Referrals come from the sector teams and the POLL team. The people who are referred usually come from Beckett Ward in St. James' Hospital, lower support accommodation, or from their own homes. Referral is by way of an application form, followed by a presentation to the Rehabilitation Committee, which includes members of all disciplines and treating teams. A Medical Research Council (MRC) needs for care assessment is completed and the person's name is added to a waiting list, which is prioritised by the rehabilitation committee.

#### PROCESS OF ADMISSION

There is a community residence specific admission policy in place. All residents are assessed prior to admission. Visits are arranged for the prospective resident who is often accompanied to the residence by a member of staff. An assessment of daily living skills is usually completed by an occupational therapist. A serious history of violence or major

mobility problems may be exclusion criteria. The residence occasionally provides a respite placement during holiday times. The decision to admit is taken by the rehabilitation committee. A key worker is appointed on admission. Residents are reviewed every ten weeks by their treating teams.

#### CARE PLAN

There is no multidisciplinary system of care planning. Following assessments, a nursing care plan is put in place and goals and objectives are set. These are reviewed on a weekly basis. The MRC assessment is repeated yearly. In the past, some residents have been discharged to lower support accommodation but none to independent accommodation. There were no discharges during the past year and no one is currently awaiting discharge to lower support accommodation.

#### NURSING PROCESS

The Roper Logan Tierney model of nursing is in use but staff reported that they were looking at other models, such as the Tidal model, that may be more appropriate. The MRC assessment contains a risk assessment. Staff wear identification badges.

#### REHABILITATION TEAM

There is no rehabilitation team in place. Residents are reviewed by members of their treating team every ten weeks. Residents can be referred immediately to their consultant psychiatrist if necessary. They are reviewed yearly by their consultant psychiatrist but they can be seen at the outpatient clinic in the interim.

#### INVOLVEMENT IN REHABILITATION PROGRAMMES

Residents are involved in individual needs-based life skills programmes. Activities organised by the residence staff include newspaper and social groups, shopping, trips to the gym, and social outings. Two of the residents are retired and five residents remain in the house during the day. Five residents attend day

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services off site, which include a centre at Cherryfield, an Eve Holdings centre and a performing arts centre. Of concern was the fact that one of the residents was out of funding and did not have an appropriate day placement at the time of inspection.

### UNIT MANAGEMENT

There are no temporary transfers due to bed shortages elsewhere in the service and there are no crisis admissions to the residence. It is self-staffing, which ensures continuity of staff. There are two nursing staff on duty during the day Monday to Friday and one at night and at weekends. There is one household staff on duty during the day. The waiting list for the community residence is managed by the Assistant Director of Nursing. The community residence managers and the Assistant Director of Nursing meet each week regarding policy issues. The rehabilitation committee meets monthly.

### ETHOS

There is emphasis on rehabilitation and on promoting independence within a homely environment. There is a policy of induction for residents and new staff work alongside established staff until they are familiar with the residence and the residents. The dress code for staff is smart casual.

### HOUSE RULES

There are written house rules for the residents and each resident signs a contract to abide by these rules prior to admission. There is no smoking indoors and residents are asked to give matches and lighters to the staff at night. There are rotas for chores within the house. There is a house meeting once a month that focuses on issues to do with the care of the house and mutual respect for residents. Visiting times are flexible. The residents do not have a front door key. Residents are encouraged to leave the house unsupervised but are asked to return by 2300h. There are no set bedtimes but residents are generally expected to go to bed before midnight; residents are not expected to get up at set times at weekends. Residents have access to the kitchen at set times

during the day but have free access to drinks. Breakfast and tea are prepared by nursing staff and residents. Lunch is prepared by household staff. Some residents are involved in shopping for the community residence. Three of the residents have their own bank accounts and manage their own finances. The money of the other residents is managed by staff. Most of the residents are able to purchase their own clothes. Residents have free access to a laundry room and four of the residents manage their own laundry. Most residents can access shops, cafes and post office on their own. There is easy access to public transport.

### SERVICE USER INVOLVEMENT

Information on treatment and therapies is usually given verbally by staff. There are some information leaflets available. There is a poster on the complaints policy. There is a monthly community meeting. There is a leaflet available on an independent advocacy service.

### RECORDS

Clinical notes were in very good order and showed evidence of regular review. There was evidence that the care plans were reviewed regularly and that progress notes were up to date. The medication sheets were up to date and legible.

### ENVIRONMENT

The community residence was nicely decorated throughout and had a homely atmosphere. There were two large lounges, a nursing office, a kitchen, a dining room, two bathrooms and three toilets. Accommodation was provided in one single room, three double rooms and one triple room. Most of the bedrooms were upstairs and suitable for residents who did not have mobility problems. A smoking area was provided outside the house. There was a large front garden.

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**QUILCA HOUSE**

*Date of inspection:* 23rd November 2005

*Number of beds:* 10 integrated

**DESCRIPTION**

Quilca community residence is a three-storey residence close to Terenure village in Dublin. On the day of inspection, there were four male and six female residents. There are no crisis or respite beds. The age range of patients is between 27 and 69 years and the majority of residents are former long-stay patients in hospital. Two of the current resident group are Wards of Court. The sector teams and the Psychiatry of Later Life (POLL) team have admitting rights and continue to provide a service to the individuals referred to the residence. It opened in 1995 and is owned the HSE, but run by St. Patrick's Hospital. Twenty-four-hour care is provided and it functions as a rehabilitation community residence and as a permanent home for some residents. There is no dedicated rehabilitation team.

**REFERRAL**

Referrals come from the sector teams and the POLL team. People who are referred usually come from Beckett Ward in St. James' Hospital, lower support accommodation, or from their own homes. Referral is by way of an application form, followed by a presentation to the Rehabilitation Committee, which includes members of all disciplines and treating teams. A Medical Research Council (MRC) needs for care assessment is completed and the person's name is added to a waiting list, which is prioritised by the rehabilitation committee.

**PROCESS OF ADMISSION**

There is a community residence specific admission policy in place. All residents are assessed prior to admission. Prospective residents visit the residence and are often accompanied by a member of staff. An assessment of daily living skills is usually completed by an occupational therapist. A serious history of violence or major mobility problems may be exclusion criteria for admission. The residence occasionally

provides a respite placement during holiday times. The decision to admit is taken by the rehabilitation committee. There is no key worker system in place. Residents are reviewed every ten weeks by their treating teams.

**CARE PLAN**

There is no multidisciplinary system of care planning. Following assessments, a nursing care plan is put in place and goals and objectives are set. These are reviewed on a weekly basis. The MRC assessment is repeated yearly. In the past, some residents have been discharged to lower support accommodation but none to independent accommodation. There were no admissions or discharges during the past year and while no one is currently awaiting discharge to lower support accommodation. Staff reported that two of the residents have the potential to move to lower support accommodation.

**NURSING PROCESS**

The Roper Logan Tierney model of nursing is in use. The MRC assessment contains a risk assessment. Staff wear identification badges.

**REHABILITATION TEAM**

There is no rehabilitation team in place. Residents are reviewed by members of their treating team every ten weeks, usually by an NCHD and a community mental health nurse. Residents can be referred immediately to their consultant psychiatrist if necessary. According to staff, most of the residents are reviewed yearly by their consultant psychiatrist but they can be seen at an outpatient clinic in the interim.

**INVOLVEMENT IN REHABILITATION PROGRAMMES**

Residents are involved in individual needs-based life skills programmes. Activities organised by the residence staff include newspaper and social groups, shopping, exercise, and social outings. A speech and language therapist runs a group with residents on a

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weekly basis. Three of the residents remain in the house during the day. Six of the residents attend day services off site, which include a centre at Cherryfield, an Eve Holdings resource centre, the workshop in St. Patrick's Hospital, and the occupational therapy department in St. James' Hospital.

### UNIT MANAGEMENT

There are no temporary transfers due to bed shortages elsewhere in the service and there are no crisis admissions to the residence. The residence is self-staffing, which ensures continuity of staff. There are two nursing staff on duty during the day Monday to Friday and one at night and at weekends. There is one household staff on duty during the day. The waiting list is managed by the Assistant Director of Nursing. The community residence managers and the Assistant Director of Nursing meet each week regarding policy issues. The rehabilitation committee meets monthly.

### ETHOS

There is emphasis on rehabilitation and on promoting independence within a homely environment. There is a policy of induction for residents, and new staff work alongside established staff until they are familiar with the residence and the residents. The dress code for staff is smart casual.

### HOUSE RULES

There are written house rules for the residents and each resident signs a contract to abide by these rules prior to admission. There is no smoking indoors. There are rotas for chores within the house. There is a house meeting once a month which focuses on issues to do with the care of the house and mutual respect for residents. Visiting times are flexible. The residents do not have a front door key. Nine of the ten residents are encouraged to leave the house unsupervised but are asked to return by 2300h. Some of the residents stay with family members at weekends. There are no set bedtimes but residents are generally expected to go to bed about 2330h. Residents are not expected to get up at set times at weekends. They have access to the kitchen at set

times during the day but have free access to a kitchenette for drinks. Breakfast and tea are prepared by nursing staff and residents. Lunch is prepared by household staff. Some residents are involved in shopping for the community residence. All have their own post office accounts and two manage their own finances. Two residents are Wards of Court and the money of the other residents is managed by staff. Three of the residents can shop independently. They have free access to a laundry room and two of the residents manage their own laundry. Most can access shops, cafes and the post office on their own. There is easy access to public transport.

### SERVICE USER INVOLVEMENT

Information on treatment and therapies and national health initiatives is usually given verbally by staff. There are some information leaflets available. There is no notice on the complaints policy. There is a monthly community meeting. There is a leaflet available on an independent advocacy service.

### RECORDS

Clinical notes were in very good order and showed evidence of regular review. There was evidence that the care plans were reviewed regularly and that progress notes were up to date. The medication sheets were up to date and legible.

### ENVIRONMENT

Most of the community residence was nicely decorated and had a homely atmosphere. There were two large adjoining lounges, a nursing office, a kitchen, a kitchenette and a dining room, two bathrooms and five toilets. Accommodation was provided in one single room, three double rooms and one triple room, which had an en-suite bathroom. There were five landings in the house and most of the bedrooms were upstairs and suitable for residents who did not have mobility problems. The main entrance hall, stairs and first landing area needed repainting. The triple room needed new carpet and wallpaper. A smoking area was provided outside the house. There was a front and back garden.

Dublin/Kildare

## ST. JAMES' HOSPITAL

### BECKETT WARD

*Date of inspection:* 22nd November 2005

*Number of beds:* 16 integrated

#### DESCRIPTION

Beckett Ward is an open 16-bed unit on the ground floor of the Jonathan Swift Clinic, which is the mental health unit in St. James' Hospital. On the day of inspection, there were 14 patients, eight female and six male. There were two vacancies. One patient was on Temporary status and the other 13 patients were on Voluntary status. There are five teams with admitting rights to the unit. The unit serves a number of purposes: it provides acute care and continuing care and it also serves as a pre-discharge unit. There is no rehabilitation team in this catchment.

#### REFERRAL

All of the patients come from William Fownes Ward.

#### PROCESS OF ADMISSION

According to staff, there is no admission policy. Patients are transferred from William Fownes Ward. Staff are informed by phone of the transfer and handover information is given.

#### CARE PLAN

The care plans that have been formulated on William Fownes Ward are transferred to Beckett Ward. After a few days, a new nursing care plan is drawn up. These identify needs, and goals and objectives are set. The other members of the multidisciplinary team are involved in meeting the patients' needs. There is no key worker system as there is only one nurse on duty at any given time, therefore this nurse takes on the role of key worker to all 16 patients. Care plans are reviewed on a weekly basis.

#### NURSING PROCESS

The staff use the Roper Logan Tierney nursing model. The current method of evaluating the care plans needs to be reviewed. There are a number of boxes penned on the sheet and large amounts of hand-written notes that do not appear to be in an organised format. Each patient on the unit has a risk assessment carried out on the admission ward. The assessments are not updated on Beckett Ward, and this also needs to be reviewed.

#### ACCESS TO THERAPY

Patients on this unit are reviewed on a regular basis by the consultant psychiatrists and the NCHDs. Staff reported that other members of the multidisciplinary team are also involved in providing treatment to this patient group. Patients can be referred to other departments within the hospital for medical and surgical consultations.

#### ACCESS TO THERAPEUTIC PROGRAMMES

Patients have access to the occupational therapy department, which is located on the same floor. Referrals can be made to social workers, psychologists and occupational therapists on the various teams. Five of the patient group do not attend any therapeutic programmes. The other patients attend day centres and a workshop but it was unclear what activities were provided in these centres and whether they were based on individual needs. Some patients attend the group activities on William Fownes Ward.

#### ECT

There is no ECT on this unit.

#### SECLUSION

There is no seclusion room and no seclusion on this unit.

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## CLINICAL RISK MANAGEMENT

There is a policy on clinical risk management and policies on alcohol and illegal drugs, patients going missing, the management of violent episodes, and on searching patients' belongings. A system is in place for the recording and auditing of serious incidents. There are six-weekly meetings of the risk management committee. Training has been made available to some staff in non-violent crisis intervention and cardio-pulmonary resuscitation. There is in-house information on medication, and further information is provided by the pharmacist. Individual risk screens are documented in files of patients who have been on William Fownes Ward recently.

## UNIT MANAGEMENT

The door to the unit is open. Most of the patients have been transferred from William Fownes Ward. Occasionally patients from Connolly Norman Ward sleep over in this unit due to bed shortages. The bedroom areas are locked between 1000h and 1200h and again between 1400h and 1600h to ensure that patients are not in the bedroom areas and to encourage them to attend groups or centres. The unit is staffed by one staff nurse during the day and one at night. One household staff and one care attendant are shared with the other two units in the Jonathan Swift Clinic. A ward clerk provides a service to the unit one day a week. A phlebotomy service is provided from the main hospital. According to staff, observation of the patients is difficult due to the layout of the unit and staff rely on colleagues in other areas of the clinic to inform them of patients' attendance at groups or programmes. Observation takes place at meal times and staff operate a checklist at night. Staff expressed the need for extra security on the unit due to its easy accessibility to the public. Activities on the unit include TV, newspaper, books and games. CCTV is not used on the unit. There is unit rostering and continuity of staffing but staffing levels are low. Visiting times are set, but there is flexibility. Meal times are 0830h, 1145h and 1645h. Drinks and snacks are available at regular intervals during the day.

## SERVICE USER INVOLVEMENT

There were information leaflets available on medication treatments and on various aspects of the service. Notices on the patients' charter and the complaints policy are displayed on the unit. There is a weekly community meeting. There is access to an advocate who visits the building on a regular basis.

## RECORDS

There was a single integrated file used on the unit. The patients' names and ID numbers were not evident in all the sheets in the medical part of the file, but were on nursing notes. Entries had full name and designation of personnel and were dated and signed. There were progress reports from the professionals involved with the patients. There were treatment plans and progress reports were dated and signed. There were regular reviews by the consultant psychiatrists and the NCHDs. The nursing notes contained appropriate care plans that were reviewed, but the process of reviewing needed to be changed. Medication sheets on the unit were satisfactory. They were signed, dated, legible, used generic names and discontinuation of medication was signed and dated.

## ENVIRONMENT

Beckett Ward was a ground floor unit with open access. The layout of the unit was far from ideal. In one area, which adjoined Connolly Norman Ward, accommodation was provided in two six bed and one four bed rooms close to the nursing office. There were also toilets and showers in this area. Another area of the unit, which was separated from the first by a corridor and garden area, comprised a TV lounge, a dining room, library and interview room and shared a corridor with the day hospital and the occupational therapy department. The nursing office doubled as a clinic room and was quite small for the purposes it served. The unit was clean throughout but the layout of the unit meant that it was impossible for the one nurse on duty to observe and interact with the patients throughout the day.

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## CONNOLLY NORMAN UNIT

*Date of inspection:* 22nd November 2005

*Number of beds:* 9

### DESCRIPTION

This is a 9-bed acute assessment unit for elderly patients. The unit is locked and on the day of inspection there was one patient on Temporary status.

### REFERRAL

The sources of referral to the unit are community teams, A&E, outpatient clinics, GPs, day hospitals and liaison psychiatry. Patients are referred through an initial telephone contact to establish whether a bed is available, and a decision is then made to admit the patient.

### PROCESS OF ADMISSION

There is no formal admission policy. The NCHD carries out the admission assessment and the nursing staff also carry out an assessment based on the Roper Logan Tierney model, incorporating some elements of a risk assessment. A physical examination is also undertaken and a collateral history obtained. The consultant psychiatrist makes the decision regarding admission and staff communicate with the patient and family members regarding the admission process. Consultant psychiatrists review the patient within 24 hours and the initial treatment plan is documented in the nursing file. A patient is placed on general observation or special (one-to-one) observation. There is no key worker system. Staff are allocated to patients on a shift-by-shift basis.

### CARE PLAN

The care plans on the unit are nurse led. They are needs identified with set goals and objectives. Other members of the multidisciplinary team are involved in this care planning where appropriate. Care plans are reviewed on a weekly basis. A discharge plan is commenced when patients are ready for discharge. It

was reported that there can be difficulties finding appropriate placements for people who no longer need acute in-patient care. All relevant parties are notified of a patient's discharge.

### NURSING PROCESS

The unit use the Roper Logan Tierney nursing model, which has been slightly adapted to the needs of the patients. There are some elements of a risk assessment carried out, especially in the area of falls and pressure area care.

### ACCESS TO THERAPY

There is a full-time occupational therapist based on the unit and a full-time social worker specifically for elderly services. There are plans to have psychology input to the unit. There is a team meeting held every Monday and all patients are reviewed by the multidisciplinary team. There is one consultant psychiatrist with clinical responsibility for the patients on the unit and patients are reviewed twice weekly. The senior registrar also attends the unit on a regular basis. The patients have access to a physiotherapist, dietician, speech and language therapist and a chiroprapist.

### ACCESS TO THERAPEUTIC PROGRAMMES

There is evidence of needs-based group therapy. Groups include reminiscence, pre-discharge group, music, art, exercise, coping with depression, positive mental health group, newspaper group, and cooking.

### ECT

There is an ECT policy and procedure in place. Consent is obtained from the consultant psychiatrist and there is written information for the patient. There is a nursing procedure and checklist and each session is recorded. There is a designated ECT nurse who coordinates all the paperwork. ECT is no longer administered on site; the patients attend St. Patrick's Hospital for ECT.

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#### CLINICAL RISK MANAGEMENT

There are policies on infection control and the risk management team undertake audits within the unit. There is a policy document in place within the unit. Staff receive training in restraint techniques, including de-escalation and breakaway techniques. They also have access to other mandatory training such as cardio-pulmonary resuscitation, manual handling, an infection control. Staff can take preceptorship courses and support is given for longer courses. There are clinical risk assessments in each patient's clinical file. Serious incidents are reported to the risk management team. There are regular meetings with the risk management team and the multidisciplinary team to develop improvements in the service. There is also debriefing available following serious incidents through the Psychology Department.

#### UNIT MANAGEMENT

There is a full programme of activities on the unit. Patients are allowed off the unit if allowed by the multidisciplinary team. The unit is locked for safety reasons. There is a CNM2, two staff nurses and an attendant on duty during the day and at night there is one staff nurse and an attendant. There is one household member of staff in the kitchen. There is a core group of staff who are based on the unit and any supplementary staff are from the central roster. There is a process of induction for staff and the dress code is uniform. There is no ward clerk and it was reported that this facility is needed. There is access to a phlebotomist. The CNM2 manages the waiting list and liaises with the team to prioritise admissions. There are currently two patients on the unit who are awaiting nursing home placement. Maintenance is provided by an on-site maintenance team. Visiting times to the unit are flexible and there are set times for meals. It was noted that the evening meal is quite early. There are drinks available for the patients throughout the day.

#### SERVICE USER INVOLVEMENT

There is no information on treatment and therapies for the patients. There is a complaints procedure but there are no information leaflets on complaints. There is a weekly meeting with the patients regarding

facilities and service delivery. There are also meetings with family and carers. It was reported that attempts at providing an advocacy service were not successful.

#### RECORDS

There were separate medical and nursing notes. Clinical files had patients' names and ID numbers on all pages. They were legible and tidy. Entries had full names and titles of personnel, were signed, dated and contained progress reports from other members of the multidisciplinary team. They contained a treatment plan, and dated and signed progress reports. Consultant psychiatrists reviewed the patients at least twice a week. The nursing notes had appropriate care plans and evidence that they were regularly reviewed. Medication cards were signed, dated and legible, used generic names and discontinuation of medication was signed and dated.

#### ENVIRONMENT

This was a small 9-bed unit in the mental health unit of the St. James's Hospital. There were regular maintenance programmes and there was disabled access. It was reported that the unit gets too warm on occasions. The décor was of a good standard and noise levels were appropriate. There was no designated visitors' area and currently no access to a garden, although this is planned in the future. The reception area was separate from the ward and there was a buzzer system to get into the ward. The bedroom areas were a 6-bed dormitory usually for females, and three single rooms. There were curtains around the beds in the dormitory and individual wardrobe space. Toilets and bathrooms were of a good standard and people had free access to them. The dining area had space for one sitting; it was integrated with a good standard of decor. There was no activity area. The lounge was used for this purpose. The lounge contained comfortable seating. The patients had access to newspapers, TV, video and radio. The nurses' station was located centrally within the unit. It was a very small room and it was reported that it is the only room available for nursing staff. There is an IT system which is internal only. The clinical room doubled as the office and had appropriate storage and appropriate medical equipment. There was limited storage for patients'

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possessions and files and records. Generally the unit was very cramped with little space for staff and patients.

**WILLIAM FOWNES WARD**

*Date of inspection:* 22nd November 2005

*Number of beds:* 26 integrated

**DESCRIPTION**

William Fownes Ward is a 26-bed acute admission unit on the first floor of the Jonathan Swift Clinic, which is the mental health unit in St. James' Hospital. On the day of inspection, there were 27 patients, 16 female and 11 male, with one patient on temporary leave. There were nine patients on Temporary status and 18 patients on Voluntary status. There are five teams with admitting rights to the unit. The unit was locked on the day of inspection.

**REFERRAL**

Referrals to the unit come from A&E, the outpatients department, GPs, the day hospital, An Garda Síochána, and self-referrals.

**PROCESS OF ADMISSION**

There is an admission policy of which staff were aware. No one under 16 years of age is admitted. People with moderate intellectual disability are sometimes admitted. There are occasional admissions for social crises. A full psychiatric and physical assessment is carried out on admission. The decision to admit is generally made by the NCHD in consultation with nursing staff but is not always cleared with the consultant psychiatrist. Nursing staff or the NCHD usually communicate with the patient about his or her treatment plan and also with the family if appropriate. The patient is reviewed by the consultant psychiatrist within 24 hours. Patients are not usually nursed in their night clothes. The level of observation is specified on admission. A key worker is appointed according to the sector of origin. Of note is the fact that liaison with the Inner City Partnership GPs has led to a new Emergency Admissions Policy. A

new Patient Assessment Form is also in use and this includes an Admission Risk Screen.

**CARE PLAN**

There is no formal system of multidisciplinary care planning in place. A nursing assessment is carried out as soon as possible after admission. A care plan is then formulated and goals and objectives are set, which are evaluated on a weekly basis. The patient is involved in this process and invited to sign the care plan. Multidisciplinary sector team meetings are held on the unit weekly. Some teams invite the patient to the meeting when their case is being discussed. Family meetings are also held on the unit. There is no formal process of discharge planning. A standardised discharge form is sent to the GP.

**NURSING PROCESS**

The Orem Roper Logan Tierney model of nursing is in operation with the focus on activities of daily living. Nurses are allocated to patients on a sector basis and this information is displayed on a notice board on the unit. These nurses attend the sector team meetings. Risk indicators are documented on assessment after admission. Observation levels are general, 15-minute and special (one-to-one). Staff wear identification badges. Dress code is smart casual.

**ACCESS TO THERAPY**

Patients have access to the occupational therapy department which is located downstairs. Referrals are made to social work, psychology and occupational therapy members of the various teams. The consultant psychiatrists visit the unit twice weekly. Patients can be transferred to other departments within the hospital for medical and surgical consultations. Staff reported that further work needs to be done on the protocols, as there can be difficulties in transferring a patient to a medical ward. The results of X-rays and laboratory tests are available through the hospital IT system.

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#### ACCESS TO THERAPEUTIC PROGRAMMES

There is a programme of groups on the unit each week. This includes a daily psychology group, a "Directive" group run by occupational therapists and nurses, and a series of pre-discharge groups run by all disciplines. Relaxation, anxiety management and smoking cessation groups are also held. Occupational therapists attend the unit for needs-based individual therapy. Patients can also access the occupational therapy department downstairs for a variety of activities.

#### ECT

ECT is not carried out on this unit. Patients are referred to St. Patrick's Hospital for ECT, on Tuesday and Friday mornings.

#### SECLUSION

There is no seclusion room and no one is secluded on this unit.

#### CLINICAL RISK MANAGEMENT

There is a policy on clinical risk management and policies on alcohol and illegal drugs, patients going missing, the management of violent episodes, and on searching patients' belongings. A policy on rapid tranquillisation is being reviewed and a policy on giving medication without consent is currently being formulated. A pinpoint alarm system is used on the unit. Physical restraint is sometimes used. This is documented in patients' files. A system is in place for the recording and auditing of serious incidents. There are six-weekly meetings of the risk management committee. Some of the staff have been trained in non-violent crisis intervention and cardio-pulmonary resuscitation. There is in-house information on medication and further information is provided by pharmaceutical representatives and the pharmacist. Individual risk screens are documented in patients' files.

#### UNIT MANAGEMENT

There is no high observation area in this unit and very disturbed patients may be transferred to St. Brendan's Hospital. Four such patients have been transferred to St. Brendan's during the past year. The door to the unit is locked but there is no formal policy on locking doors in place. Activities and resources on the unit include TV, newspaper, games and art materials. The beds of patients who are on leave or on weekend pass are sometimes used due to bed shortages. CCTV is not used on the unit. There is unit rostering. The unit is staffed by a CNM2 or CNM1 and four staff nurses during the day and three staff nurses at night. There is one household staff on duty in the kitchen during the day and the cleaning of the unit is done by contract cleaners. There is an induction process for staff and a ward profile. A ward clerk is available on a half-time basis. A phlebotomy service is provided from the main hospital. The nurse manager manages the waiting list. There are two patients waiting appropriate discharge placements. Visiting times are set but there is flexibility for next of kin. Meal times are 0830h, 1145h and 1645h. Drinks and snacks are available at regular intervals during the day.

#### SERVICE USER INVOLVEMENT

There is a written treatment contract, which each patient is asked to sign on admission and abide by during their stay. There were information leaflets available on medication treatments and on various aspects of the service. Information boards have been purchased but not yet erected. Notices on the patients' charter and the complaints policy are displayed and a programme of weekly activities is also posted. There is a weekly community meeting. An advocate visits the unit on a regular basis.

#### RECORDS

The clinical files were integrated and contained the patients' names and ID numbers. Entries were legible, signed and dated, but they did not always contain the full name or title of the person making the entry. They contained treatment plans, regular reviews and also contained progress notes from most members of the multidisciplinary teams. The files were unwieldy with many loose pages. A signature bank was

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available for nursing staff. The medication sheets were legible, signed and dated. However the discontinuations were not always signed and dated.

## ENVIRONMENT

William Fownes is a first-floor unit and can be accessed by stairs or lift. The entrance to the unit was not very welcoming. There was a locked door with a buzzer. There was no receptionist and the door had to be opened by nursing staff. There were no chairs outside the door so visitors have to stand and wait until the door is opened. There was no camera to assist staff in identifying the caller. The lock on the main door was faulty and could be pushed open from inside. There was no dedicated admissions area. The unit as a whole seemed quite small for the number of patients and the décor was not of a high standard. Accommodation was provided in six single bedrooms and a range of 4-bed and 6-bed rooms. There were sufficient toilets and bathrooms and these had over riding locks and were wheelchair accessible. The nursing office was very cramped and had insufficient space for report writing and storage. The interview room had an observation panel installed since the last inspection. The former smoking room had been converted into a general purpose room and was nicely furnished but patients did not have free access to this room. A new smoking room was in operation but this was extremely small and dirty. There was no designated outside smoking area but patients had access to a garden downstairs. There was a clinical room, where medication was stored and a range of other store rooms. The dining area had sufficient space for one sitting and there was one TV room. There was an administration corridor off the unit, which contained the conference room and the offices of various members of the multidisciplinary teams.

## NAAS GENERAL HOSPITAL

## LAKEVIEW

*Date of inspection:* 28th November 2005

*Number of beds:* 29 integrated, 1 seclusion room

## DESCRIPTION

This is an integrated 29-bed unit for a population of 180,000 people. The acute unit has five admitting teams and there is access to one seclusion room. On the day of the inspection, there were eight patients on Temporary status.

## REFERRAL

There are two distinct pathways for admission. The sector consultant psychiatrist can directly refer into the unit following an assessment in a community facility. All other referrals are via A&E. The patient is medically screened and reviewed by the NCHD. The consultant psychiatrist on duty must make the final decision on all admissions.

## PROCESS OF ADMISSION

There is an admission policy in place. Each patient is asked to sign to indicate they understand the housekeeping rules for the unit and this is filed in each chart. All admission have a full assessment and are reviewed by the consultant psychiatrist at the next available date. There is communication with patients' GP on discharge and it is policy that a discharge letter is sent within 24 hours. Patients are not routinely nursed in bed clothes on admission. There are two levels of observation (general and one-to-one nursing). Each patient has a key nurse and nurses are allocated to sector teams daily.

## CARE PLAN

There is a group looking at the introduction of multidisciplinary care plans. Currently medical and nursing staff documents plans separately. There are team meetings held on the unit. The frequency and

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location of these meetings varies according to sector team. In addition to a discharge letter being sent to a GP., the nursing staff fax a nursing discharge sheet to the sector headquarters or day hospital outlining the plan.

#### NURSING PROCESS

The nursing model in use is an eclectic model, developed in-house. There is no formal risk assessment on each patient. It was reported to the Inspector that this is under review. The Functional Analysis of Care Environment (FACE) assessment has been purchased by the service and it is hoped to be introduced. The nursing documentation has recently been linked to a standard. The nursing notes will be audited in December 2005.

#### ACCESS TO THERAPY

There are five consultant-led teams. The rehabilitation team consultant has also been appointed Clinical Director recently. It is hoped that the rehabilitation team will be appointed in early 2006. The five general adult sector teams have access to social work and occupational therapy members. There is only one clinical psychologist to the service. There is also a senior occupational therapist based on the acute unit. Medical and surgical consultations are provided by the general hospital. A clinical nurse specialist in addiction is based in A&E. The unit is managed by a CNM3. The unit facilitates student placements for occupational therapy, nursing and students from An Garda Síochána.

#### ACCESS TO THERAPEUTIC PROGRAMMES

Occupational therapy and nursing staff deliver a group-based programme. The programme is needs based and patients have weekly input into formulating the programme. The nursing staff file a report sheet on the groups to the Assistant Director of Nursing daily. This is not recorded in the main chart. Access to an enclosed garden space is nearing completion and it was reported that it would be open by the end of the week. A CNM1, a staff nurse and senior occupational therapist staff the area.

There is access to a clinical nurse specialist in rehabilitation and a clinical nurse specialist in drama therapy.

#### ECT

There is a detailed policy and procedure. There is an ECT register documenting the number of patients who have received ECT. Written information on ECT is available for all patients. The system in place involves a nurse completing the pre-ECT checklist and accompanying the patient and monitoring their recovery. In addition there is a dedicated ECT nurse. There is also a designated ECT consultant psychiatrist. The dedicated ECT suite is located upstairs in the therapy area. There are two waiting areas in the ECT suite to afford privacy and confidentiality. Preparation and administration of ECT occur in the same room. There are three beds in the recovery room. The ECT machine in use is the MECTA SR2. The consultant anaesthetist from the pain management clinic provides the anaesthetic service for ECT. There is ambulant monitoring using the Verida M3 monitor.

#### SECLUSION

There is a seclusion room on the unit. There is a seclusion policy and a register that has been kept up to date. The room itself is clean, safe and has a green sports finish. It was ventilated and well lit with an outside control panel for the room. There is an en-suite toilet, shower and wash-hand basin. There is an observation panel in the door. Refractory clothing is not used as a rule. Generally patients are nursed in their night attire if in the seclusion room. There is CCTV monitoring of the seclusion room with the monitor in the nurses' station. The seclusion room is not part of the ward bed complement. The seclusion register was completed accurately; however it was not always countersigned by the consultant psychiatrist.

#### CLINICAL RISK MANAGEMENT

All unit policies are currently under review. All staff carry alarms and there is an external response from security in the hospital. Mechanical restraint is not in

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use. All staff are trained in prevention and management of violence techniques. The procedure for administering drugs without consent is not documented. Training is provided for staff on an ongoing basis. It is hoped that a formal clinical risk assessment currently under pilot will be introduced to all aspects of the service. Incidents are recorded and reported as per the HSE South Western Area policy.

### UNIT MANAGEMENT

The ward is staffed daily by a CNM2 at week-ends, a CNM1 and five staff nurses. At night there are four staff nurses on duty. There is an Assistant Director of Nursing with responsibility for the unit. There is one CNM1, one staff nurse and one occupational therapist in the activation area. The staff are supported by two domestic staff members, one hospital cleaner and contract cleaners. Due to pressure on beds, patients are discharged on pass to 24-hour nurse-staffed hostels. It was reported that this amounts to about eight such discharges on pass a year. Currently there is a clozapine clinic held on the unit. This will be moved to the outpatient department next week. The unit door is locked. Access is gained by intercom for visitors and swipe card for staff. There is no corresponding policy in place. The staff are self-staffing and remain on the unit for two years. Each new staff member receives an induction. The wearing of a uniform is optional. The unit has a full-time ward clerk and access to the hospital phlebotomist. A number of nursing staff are also trained in this technique and one nurse is responsible for ECT and clozapine monitoring. Medical and nursing staff reviews the waiting list for admission daily. It was reported that there are currently 11 patients on the unit who are inappropriately placed. The seclusion room is often used as an additional bed. The food is prepared in the hospital and was reported to be of high quality. Visiting times are set and there is a visitors' code on view at the entrance to the unit.

### SERVICE USER INVOLVEMENT

There are three information leaflets: an information booklet, information about the therapy area, and information on patients' rights. All are located in a central area. A complaints policy is under

development. Currently complaints are dealt with locally as per local policy. There is a suggestion box located at the main door. The Irish Advocacy Network does not visit the unit.

One client was interviewed at his own request. He wanted to highlight how much he appreciated the standard of care that he was receiving in the unit. He said he was very happy there and he had absolutely no complaints.

### RECORDS

Patients' names were not on all pages of the clinical file. The files were legible and tidy. And all entries were all signed and dated. There is a need to have a medical signature bank available. The designation of medical staff making the entries should also be entered. There was evidence of regular consultant psychiatrist and NCHD review. The nursing notes were satisfactory, but again designation of personnel should be entered. In some sectors the charts are integrated so that the medical and nursing notes are in the same case file. With regard to medical prescriptions and administration records, some of the card indexes were not correctly signed. In other respects they were satisfactory. The chart of a patient who had been treated with ECT was reviewed and the record of ECT was satisfactory. There is a need to record that seclusion has been discontinued.

### ENVIRONMENT

This is a spacious two-storey unit in the grounds of a general hospital. The ward, in common with other units in the hospital, operates on a swipe card mechanism and doorbell. Visitors to the ward are now encouraged to enter via the upper level, which is in close proximity to the entrance to the general hospital. There is a receptionist inside this main entrance and a waiting area. The therapy rooms and ECT suite, dining room and kitchen are all on this level. The sleeping areas are downstairs. The rooftop garden is not yet accessible to patients although a number of measures have been taken to ensure that it is rendered safe and the Inspector was informed that it would be opening shortly. It had recently been replanted and reconfigured. On this level there are a number of rooms for therapy. There is a multifunction room with table tennis tables and pool

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tables, dart boards. In addition there is an arts and pottery room. There are facilities for a hairdresser and foot-baths. There are laundry facilities that patients can access if they wish and are able. The male and female toilets were satisfactory. There is a training kitchen, three consultant psychiatrists' offices and a number of nursing staff offices. The occupational therapist also has an office on this level. There is a TV room/quiet area. There is also a quiet room overlooking the lake and there is a dining room that is pleasant and overlooks the lake, with a serving area just off it. There is a multi-sensory room. There is an office for the therapy staff. In the corridors there was a football game and an exercise bike. In general this was a pleasant, nicely decorated area. In the reception area upstairs there are notice boards and leaflets providing ample information for the residents about the therapies and complaints procedures. There was a clearly posted code of conduct on the entrance to the unit. Visitors can attend at the bedside or in the sitting room or the quiet room. There are a number of facilities available to them. Downstairs there are two 6-bed rooms for observation purposes and another three bedrooms with four beds in each. There are also four single rooms. In the dormitories there are curtains around each of the beds. There are gender specific toilets for male and female downstairs to which there is free access. There is one shower room and one bathroom, both suitable for those with disability. There is one single room which has an en-suite which is used for mothers and babies, or for specific clinical indications. Bathrooms all have overriding locks. The interview room is downstairs. In addition, there is a nurses' station that contains the files and the alarm system and is very readily accessible to all patients on the unit. There is a nurses' desk on the ward which leads into the clinical room and this area is sometimes used for report writing. All alarms are checked every time one is removed from the office by means of a locator on the wall. There are outside lines as well as connections with the hospital and a computer system on the unit. The clinical room did not contain an examination couch. It did contain medical equipment, including cardio-pulmonary resuscitation, defibrillator, oxygen suction and waste disposal. The staff have a rest room upstairs and toilets and showers. They have access to the library in the hospital and there is Internet access. There is ample storage on the unit. CCTV is only used in the seclusion room.

## ST. LOMAN'S

## REHABILITATION UNIT

*Date of inspection:* 28th November 2005

*Number of beds:* 22

## DESCRIPTION

This is a 22-bed unit described as a rehabilitation ward within St. Loman's Hospital. This ward has an open door policy and on the day of inspection there were no detained patients.

## REFERRAL

The sources of referral to the unit are the acute unit in Tallaght Hospital and community teams, and there are beds available for respite. The consultant psychiatrist and nursing staff carry out an assessment and formulate a treatment plan. It was reported that there is a fairly static population in the unit and a number of patients have long-term needs. It was also reported that on occasion there are bed shortages in the acute unit and this forces transfer from the acute unit to the rehabilitation unit.

## PROCESS OF ADMISSION

Patients with a moderate intellectual disability are rarely admitted to the unit. On admission patients receive a mental state examination, a nursing assessment and an occupational therapy assessment. A physical examination is performed and a collateral history obtained. The decision to admit a patient is usually carried out in partnership within the team but the consultant psychiatrist makes the final decision. The staff communicate with the patient as much as possible regarding the admission process and family members are also involved. The patient is reviewed by the consultant psychiatrist within 24 hours and the initial treatment plan is filed in the nursing and medical notes. There is a policy on nursing patients in night clothes during the day but there are no observation levels needed other than general observation. There is a key worker system in operation and the unit is self-staffing.

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### CARE PLAN

Care plans are nurse led, are needs identified, and have goals and objectives identified. It was reported that the main components of a multidisciplinary team are available to the unit. Care plans are reviewed on a monthly basis. There are no formal mechanisms for documented participation by the patient in the care planning process. When a patient is ready to move from the unit a gradual plan and process is put into place for discharge.

### NURSING PROCESS

Staff reported that they use a modified version of the Roper Logan Tierney nursing model. It was described as not wholly appropriate to the needs of the patients. The care plans are implemented by the key worker. There are no formal individual risk assessments undertaken.

### ACCESS TO THERAPY

There is no psychologist input on the unit. There is a part-time occupational therapist based on the unit and a part-time social worker accessible to the unit. There is one consultant psychiatrist responsible for patients on the unit who carries out a weekly review.

### ACCESS TO THERAPEUTIC PROGRAMMES

A number of patients attend activities away from the unit. A community residence called Teach Bán provides a day service. It was reported by the staff that a number of patients could be transferred to this facility if it were staffed on a 24-hour basis. Other patients visit day centres in the local community. There are between six and eight patients who remain on the unit and there is an activities programme on the unit. However there is a vacant recreation post at present.

### CLINICAL RISK MANAGEMENT

There is a detailed policy folder within the unit and all policies are in date. It was noted that there is no

policy on individual risk management for the patients. Staff receive a variety of training courses, including control and restraint, which includes de-escalation and breakaway techniques, cardio-pulmonary resuscitation, and other mandatory training. Staff are encouraged to undertake longer courses. Serious incidents are recorded on appropriate forms and sent to management but there is no feedback to the unit.

### UNIT MANAGEMENT

There are no temporary transfers from the unit although there can be pressure from the acute unit in Tallaght Hospital to transfer patients if there is a vacant bed on the rehabilitation unit. There are activities available on the unit and patients are able to leave when they wish. The door is locked at night for safety reasons. There is one person nursed in their night clothes to prevent them from leaving the unit. During the day there is a CNM2 and a CNM1 on duty along with three staff nurses and one attendant. At night there is one staff nurse and a hospital attendant, and a staff nurse works a twilight shift each evening. There is also a CNM3 on duty during the night. The unit also provides a staff nurse to Teach Bán from 0900h to 1700h. There are two full-time and one part-time household assigned to the unit. It was reported that three patients could move to other accommodation. Two patients require nursing home accommodation and it was suggested that one other patient could be transferred to St. Joseph's Unit in St. Loman's Hospital. Visiting times to the unit are flexible. There are set times for meals, which are provided on a cook-chill basis. The staff reported that this was not of high quality and a number of the patients complained about the food. There is availability of snacks and drinks in between meals.

### SERVICE USER INVOLVEMENT

There is information on treatment and therapies available. There is a complaints procedure and complaints are followed up. There is a unit community meeting held weekly and there is access to advocacy.

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## RECORDS

Patients' names and ID numbers were on each page of the notes. Entries had full the name and title of personnel and were signed and dated. There were progress reports from other professionals if involved and there was a treatment plan. The consultant psychiatrist reviews the patients on a weekly basis. The nursing files were legible and tidy and contained a patient assessment and daily interventions. Medication charts were appropriate.

## ENVIRONMENT

This was a 22-bed large unit on a single floor in St. Loman's Hospital. There was a regular maintenance programme and disabled access. There was adequate lighting and ventilation. The décor was of a good standard and the noise levels were appropriate. There were sufficient information boards with relevant notices. There was access to the grounds of the hospital. The bedrooms afforded as much privacy and dignity as possible. They were a combination of 4-bed and 2-bed dormitories. There were curtains around the beds and individual wardrobe spaces. The toilets and bathrooms were of a good standard and gender specific. The dining area was fairly large with space for one sitting and was integrated. There was a separate activity area which the patients remaining on the unit attended. The lounge areas had comfortable seating and the patients had access to daily newspapers, TV, video, radio and books. The nursing station was located centrally, it was confidential, had space for report writing and was accessible. There was a telephone and IT system. The clinical room was appropriate with appropriate equipment stored. There was adequate storage in the unit for patients' possessions.

## ST. JOSEPH'S UNIT

*Date of inspection:* 28th November 2005

*Number of beds:* 25 integrated (18 male, 7 female)

## DESCRIPTION

St. Joseph's Unit is located in the grounds of St. Loman's Hospital. It is a de-designated unit and all patients are discharged. However the unit is locked on a continuous basis. The age range is from mid-thirties to mid-seventies. The unit caters for a diverse group of patients, including those with enduring mental illness, challenging behaviour and dementia.

## REFERRAL

There are few referrals and admissions to the unit and the last admission was one year ago. Most patients have been in St. Loman's Hospital for many years and have been in other units which have now closed. Some patients have been referred from hostels in the catchment area and from other hospitals. Referrals may also come from the Acute Psychiatric Unit in Tallaght (AMINCH). Referrals are assessed by the consultant psychiatrist in rehabilitation.

## PROCESS OF ADMISSION

Following referral, patients are assessed by the nursing staff and GP prior to admission. A psychiatric assessment is carried out at the time of admission.

## CARE PLAN

The care plan is a nursing care plan based on the Roper Logan Tierney model of nursing. A detailed nursing assessment is carried out initially. There was no evidence in the care plans of regular review and evaluation of the care plan. Progress notes are written daily. There are no multidisciplinary care plans and there have been no assessments of patients regarding their accommodation needs or any rehabilitation assessments and it was unclear what the future plans are for these patients.

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**NURSING PROCESS**

There are four nursing staff on duty during the day and two on duty at night. An additional care assistant or nursing staff may be available if required. The patient group is divided into two groups and nurses assigned to each group. There is difficulty in implementing an effective key worker system due to lack of continuity of staff. There are occasional episodes of one-to-one nursing, otherwise there is general observation.

**ACCESS TO THERAPY**

There is social work input to the unit and a number of patients are in the process of obtaining their welfare entitlements. There is also a contact number displayed on the unit through which patients can access the social worker themselves. The social worker attends the monthly team meeting. There is no psychologist or occupational therapist for patients on the unit. There is a monthly team meeting attended by the consultant psychiatrist, social worker, Assistant Director of Nursing and nursing staff. There is no regular input from the consultant psychiatrist and patients are not reviewed unless there is a request for review by nursing staff. A GP attends the unit daily and provides an excellent medical service.

**ACCESS TO THERAPEUTIC PROGRAMMES**

Some patients attend an activation unit adjacent to the unit and there is an activation nurse available three days a week. Four patients attend a local day centre. There are no activities for patients on the unit apart from TV, for example there are no newspapers available. The nursing staff take a number of patients on outings each week.

**SECLUSION**

There is no seclusion on the unit. However one female patient is locked in her room at night and has an alarm on the door. It is stated that this is for her protection.

**CLINICAL RISK MANAGEMENT**

There were clear up-to-date policies on patients missing from the unit, searching patients and alcohol and drugs. There is a new incident reporting system. There is no restraint used on the unit.

**UNIT MANAGEMENT**

The unit is locked at all times, due to the fact that some patients are confused and that others may leave the unit. Patients have to ask to go out. Patients are in receipt of pensions and disability allowances which are collected by the hospital administration. Rent is deducted from each allowance and patients should receive the remaining €35 as spending money. However, this is collected by the nursing staff and put into one single fund in the unit. Drawings are made from this fund for outings, parties, communal cigarettes, beer and other communal items. Patients are given money from this collective fund for specific items and one patient receives money if his behaviour is acceptable. Patients have no individual access to their own money despite the fact that they are discharged patients. There is no policy on financial management in the unit.

There are two household staff on duty during the day. Some patients had their own keys to their rooms. Patients have little say in the menu but staff meet with catering staff to communicate difficulties with the meals provided. There are monthly meetings of the rehabilitation executive (consultant psychiatrist in rehabilitation, Assistant Director of Nursing, social worker and CNM2).

**SERVICE USER INVOLVEMENT**

There is a patient charter displayed on the unit. There are no information leaflets for the patients. The Irish Advocacy Network does not come to the unit. Patients complained to the Inspectorate about the quality of the food which came to the unit in the cook-chill system. Relatives of one patient expressed their satisfaction at the care provided. It is planned that a user group will be set up in January 2006.

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## RECORDS

The clinical files showed evidence of extensive medical input from the GP service. There were no psychiatric reviews documented over the past two years in any of the clinical files inspected, which is unacceptable in such a disabled group of patients. The medication sheets were rewritten regularly by the GP, were legible and dated. Discontinuation of medication was signed and dated. The care plans inspected showed no review of formal evaluation for over one year.

## ENVIRONMENT

The unit was arranged along two intersecting corridors with rooms on either side. The unit was unacceptably dirty and there were cobwebs hanging down within reach in a number of areas. Paint was peeling from the walls and ceiling and there was a hole in the wall along one of the corridors. The floor coverings had holes in some places and were in poor condition. The condition of the toilets was extremely poor, both in décor and in lack of cleanliness. All the toilets were dirty with faecal smearing evident on the walls of one toilet. All the toilet bowls were filthy and the floors were dirty. The Parker bath was also dirty. The linen and store rooms were untidy and the floors of these rooms were covered in dust and dirt.

There were a number of single bedrooms, some of which had a number of personal possessions. There were also triple rooms. One triple room did not have curtains around the beds. Each patient had their own wardrobe with personal clothing. There were two sitting rooms, one of which was a smoking room. The furniture was institutional in appearance and the rooms were gloomy. There was a smoking area outside and a pleasant patio and barbecue area. The dining room was brighter but required repainting. The clinic room was adequately equipped. There was an adequately sized nurses' office.

## SECOND INSPECTION: ST. LOMAN'S HOSPITAL, PALMERSTOWN, DUBLIN

Following the inspection of St. Loman's Hospital, the Inspectorate had a number of concerns about the care and treatment of residents in St. Joseph's Unit. These were as follows:

1. The lack of consultant psychiatrist reviews of residents.
2. The lack of regular review and evaluations of residents documented in the nursing care plans.
3. The absence of assessment of residents regarding future accommodation and other care needs.
4. Discharged residents being accommodated in a locked unit.
5. Residents' money being pooled and used for communal purposes without their consent. Residents did not have access to their own money and no accounts were available to residents as to how their money was being spent.
6. The unit was dirty and in need of urgent maintenance.

The senior management team was notified in writing of these concerns and asked to address the issues. They were also informed that an unannounced second inspection would take place within three months to ensure that these issues were addressed. The second inspection of St. Joseph's Unit in St. Loman's Hospital took place on 7th February 2006. This took the form of an unannounced visit to the hospital to inspect St. Joseph's Unit.

At the time of this second inspection, the Inspectorate found that consultant psychiatrist review of residents had commenced and that the lack of adequate care planning for residents was being addressed. The Inspectorate was informed that the occupational therapist had commenced assessments of residents on the unit. The practice of pooling residents' allowances on the unit had ceased. Each patient had an individual account on the unit and there had been agreement to refund monies owed to residents. However St. Joseph's Unit remained locked

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despite the fact that residents in the unit are discharged. The Inspectorate also found that the general hygiene and maintenance of the unit continued to be unsatisfactory.

Following the second inspection the Clinical Director of the service outlined plans to close this unit in the first half of 2006, with residents being accommodated in more appropriate accommodation.

A report on the above findings was made by the Inspectorate to the Mental Health Commission.

The Mental Health Commission requested a report by April 2006 in relation to the proposed closure of St. Joseph's Unit and stated its intention to continue to closely monitor the service.

## ADELAIDE & MEATH INCORPORATING THE NATIONAL CHILDREN'S HOSPITAL (TALLAGHT)

### ACUTE PSYCHIATRIC UNIT

*Date of inspection:* 29th November 2005

*Number of beds:* 52 integrated

#### DESCRIPTION

The acute unit is located in Adelaide & Meath incorporating the National Children's Hospital (Tallaght). It was opened six years ago. It has recently opened a new 6-bed high observation area with dedicated nursing staff. There are seven teams with admitting rights to the unit.

#### REFERRAL

Referrals come from A&E, the outpatients department and from GPs. There is a consultant liaison psychiatrist and a liaison nurse. All patients have a full psychiatric assessment prior to admission.

#### PROCESS OF ADMISSION

There is an admission policy of which staff were aware. No one under 16 years of age is admitted.

People with moderate intellectual disability are admitted and followed up by the sector team. There are admissions for detoxification with co-morbid mental health problems, and for social crises. A full psychiatric assessment and physical assessment is carried out on admission. The decision to admit is generally made by the NCHD in consultation with the consultant psychiatrist. Nursing staff usually communicate with the patient about his or her treatment plan and also with the family if appropriate. The patient is reviewed by the consultant psychiatrist within 24 hours. Patients with Temporary status are usually nursed in their night clothes and newly admitted patients are accommodated near the nursing office. A key worker is appointed according to sector.

#### CARE PLAN

There is no formal system of multidisciplinary care planning in place but new admissions are discussed at the sector team meetings. Once the patient has settled on the unit, a nursing assessment is carried out and a care plan is drawn up in conjunction with the patient and goals and objectives are set. These are reviewed on a regular basis. Discharge plans are discussed at team meetings. In the high observation area there was a nursing care plan particular to the hospital. A 72-hour assessment of risk was carried out on each patient. As some patients may be on high doses of medication 8-hourly physical observations were also performed. Staff from the unit attend the team meetings.

#### NURSING PROCESS

The Roper Logan Tierney model of nursing is in operation with the focus on activities of daily living. Staff felt that this model may not be the most appropriate model for this patient group. A Risk of Violence Assessment (ROVA) is carried out on all patients. Observation levels are general and special (one-to-one). A key worker system is in place. Key working in the high observation unit is gender based. Staff wear identification badges, which can be used as swipe cards. Dress code is smart casual.

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#### ACCESS TO THERAPY

There is access to a social worker or psychologist through the sector teams. Occupational therapists are available on site. The consultant psychiatrists visit the unit two or three times weekly and review the patients weekly. In the high observation area, each patient was reviewed daily by medical staff. Referrals can be made within the hospital to medical and surgical teams, who will visit the unit. The results of X-rays and laboratory tests are available on the hospital IT system. A dietician is also available to patients.

#### ACCESS TO THERAPEUTIC PROGRAMMES

There is an occupational therapy department in the unit and two sector-based occupational therapists. Patients are referred to programmes according to need. Groups include creative writing, art, gardening cookery, relaxation, life skills and memory groups. There is also a sessional music therapist. There is a group room, activity room and kitchen in the department. Occupational therapy input has just begun in the high observation unit. Assessments, reviews and progress during occupational therapy programmes are fed back to the multidisciplinary team meetings and documented in the clinical files. The snoezelen room is also available and sessions are conducted by nursing and occupational therapy staff. According to patients who were interviewed, more activities are required for patients at weekends.

#### ECT

ECT is carried out on the unit on Mondays, Wednesdays and Fridays. There is a waiting area which was open, a treatment room and a recovery room with four beds. There is a consultant psychiatrist with responsibility for ECT. There are two nursing staff trained in ECT. There is an ECT register and checklist.

#### SECLUSION

There was a seclusion room in each sleeping area. The rooms were clean and safe, although the floors in one were very worn and the surface of the floor was peeling. There was access to toilets and showers.

There was outside control of heating, light and ventilation and there was a safety mattress in each room. The windows were clear glass and this necessitated the blinds being drawn when the room was occupied. Refractory clothing was not used.

#### CLINICAL RISK MANAGEMENT

There is a policy on clinical risk management and policies on alcohol and illegal drugs, patients missing from the unit, the management of violent episodes, giving medication without consent and on searching patients' belongings. A policy on rapid tranquillisation is in draft form. A pinpoint alarm system is used on the unit but there are insufficient alarms for all staff to have one. Physical restraint is sometimes used. This is documented in patients' files and incident forms are completed and audited. Some staff have been trained in control and restraint and cardio-pulmonary resuscitation. Staff reported a difficulty in releasing staff for training as there is a large number of agency staff on the unit. A pharmacist is available daily. Individual risk assessments are documented in patients' files.

#### UNIT MANAGEMENT

There are no temporary transfers to other units although, within the unit, patients are sometimes transferred to the Aspen unit from the Rowan or Cedar areas. There have been transfers from Naas Hospital due to bed shortages there. The beds of patients who are on leave, or on weekend leave, are sometimes used due to bed shortages. Since the opening of Aspen, the main door to the unit is open from 0900h to 1700h daily. It can be locked, however, at the discretion of nursing staff if they are concerned about a particular patient leaving the unit. This is authorised by the consultant psychiatrist. This policy is due to be reviewed after six months. The nurse in charge decides which patients are allowed to leave the unit. There is central rostering from St. Loman's Hospital. Staff shortages mean that there is a large number of agency staff being used on the unit. There are two CNM2s, two CNM1s, eight staff nurses and a resource nurse on duty during the day in Rowan and Cedar and six staff nurses on duty at night. There are two household staff and two care attendants on duty during the day.

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The high observation area (Aspen) had one CMN2 and three other staff on duty each day. This is a gender-integrated unit and there was at least one male and one female staff on duty during the day. Every effort is made to ensure continuity of staffing in this unit. Of concern was the extensive use of CCTV in Aspen, which was operational in bedrooms as well as the corridors and sitting room. It was stated that there was no recording of patients. According to staff at the time of the inspection, there was no written policy regarding the use of CCTV in the unit and no guidelines concerning preserving privacy and dignity of patients while using CCTV. There were no notices stating that CCTV was in operation at the time of inspection and patients would not necessarily be aware that they were being monitored throughout the unit and in their bedrooms. The use of CCTV in this manner raises serious concerns about infringements of a persons' right to privacy. Following a request for the policy on CCTV, it was subsequently reported to the Inspectorate that patients are informed of the CCTV policy verbally and that patients are reassured as to privacy issues such as drawing curtains around the bed to ensure privacy and a written policy stating that CCTV is used, that images are not recorded and that patient privacy and dignity will be maintained at all times, is displayed.

There are two administrative staff on duty at reception. Phlebotomy services are provided from within the hospital. Visiting times are flexible. Meal times are 0900h, 1300h and 1700h. Snacks and drinks are supplied during the day and a vending machine is available. Most patients can access the hospital shop.

### SERVICE USER INVOLVEMENT

There was information available on treatment and therapies. There were leaflets on the unit about the service and other health and social services. There is an information pack containing information about 28 medications in use on the unit. Notices on the complaints policy were posted. Suggestion boxes were available. Community meetings take place in the occupational therapy department. There is access to an advocate.

### RECORDS

The clinical files were in excellent condition and showed evidence of regular reviews by consultant psychiatrists and NCHDs. There was a case summary in the file and a discharge plan. The medication sheets were legible, signed and dated. However the discontinuations in most cases were not signed and dated. The care plans were up to date and showed evidence of review.

### ENVIRONMENT

The unit had recently been re-decorated and was in good condition. All areas were bright and clean. New furniture had been ordered for some areas. There was a reception and waiting area with comfortable chairs and access to toilets. There were male (Rowan) and female (Cedar) sleeping areas with separate nursing stations and offices. The dormitories were a mix of 6-bed and 4-bed rooms and could all be observed from the nurses' stations. All beds had curtains and wardrobes. There were also a number of single rooms. There were separate TV lounges in each area. There was a large day room with sufficient chairs for a large number of people. This was used for a variety of functions, such as concerts, meetings and watching videos. Gym equipment had been ordered for this room. The kitchen and dining rooms were pleasant and bright. There was sufficient space for all patients at one sitting. A suggestion box had been placed in this area. There was a resource room, which was used by staff and students. There were a number of interview rooms. There was also a visitors' room, which needed repainting. Two rooms were used for a football table and a pool table. There was a snoezelen room. A smoking room in the unit had been closed but was re-opened recently. Payphones were available for patients but were not very private. There was free access to an enclosed garden. There is a gazebo for smoking in the garden. There was an administrative corridor with offices and meeting rooms and this area was accessed by swipe card.

The high observation unit (Aspen) was a 6-bed unit with four single bedrooms and one double room. There was a dining room/sitting room with TV and games. This room led out to an enclosed garden with a gazebo for smoking. There was also a small pantry. There was no interview room. The Psychiatry of Later Life (POLL) team retained two offices in this unit.

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There was an ongoing problem with privacy in the unit as a whole, as people using the adjoining car park and the Luas line could see into the unit. Sixty-five windows had already been replaced by tinted windows and more windows were due to be replaced in the near future. There was also a problem with blockages in some of the toilets.

**BEAUFORT HOUSE**

*Date of inspection:* 29th November 2005

*Number of beds:* 10 integrated

**DESCRIPTION**

Beaufort House is a two-storey residence in Tallaght village, Dublin. On the day of inspection, there were five male and five female residents. There are no crisis or respite beds. The age range of patients is between 23 and 72 years. There is a dedicated rehabilitation team, which has admitting rights to the residence. The residence, which was previously owned by a religious order, opened in 1998 and is owned by the HSE. Twenty-four-hour care is provided and the residence functions as a rehabilitation community residence and as a permanent home for some residents.

**REFERRAL**

Referrals come from the St. Loman's Hospital, the acute admission unit in Tallaght, and from other residences in the service. Referrals are sent to the consultant rehabilitation psychiatrist and are then discussed by the Rehabilitation Executive, comprised of representatives of the multidisciplinary teams, who make a decision on whether to admit. A full assessment, including the Risk of Violence Assessment (ROVA) is carried out prior to a decision being made.

**PROCESS OF ADMISSION**

There is an admission policy in place, which is specific to the 24-hour supervised community residences. The ROVA assessment may indicate reasons for exclusion. People are usually admitted for the purpose of participating in a rehabilitation programme but the

residence occasionally provides a respite placement during weekends. Some people come to the residence on a day basis. Residents are given a full psychiatric assessment before and after admission and a physical assessment is carried out by the GP. The CNM2 takes on the role of key worker, communicates with the resident regarding their initial treatment plan, and liaises with the family if appropriate.

**CARE PLAN**

The care plan is nurse led. Following an assessment of needs, a care plan is put in place and goals and objectives are set which are reviewed on an ongoing basis. Of the current resident group, staff considered that three are appropriate for medium support placements and three residents are appropriate for a nursing home placement. One resident has intellectual disabilities and discussions are ongoing about securing a more appropriate placement. The funding of such a placement appears to be causing difficulties. Two residents have moved to lower support placements in the past 12 months.

**NURSING PROCESS**

The ELSIE and Morningside Rehabilitation Scale is in use but staff reported that they were looking at other models that may be more appropriate. A risk assessment is carried out on all residents and a key worker system is in place. Staff do not wear identification badges.

**REHABILITATION TEAM**

There is a rehabilitation team in place but staff were unsure of the multidisciplinary personnel of the team. Members of the rehabilitation team visit Beaufort House and reviewed the progress of three residents. Each resident is reviewed by the consultant psychiatrist every three months.

**INVOLVEMENT IN REHABILITATION PROGRAMMES**

Residents are involved in individual needs-based life skills programmes. These include life skills training in socialisation, literacy, budgeting, cooking and laundry. There are organised outings once a month

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and other social activities are provided. Three residents attend a centre in Cherryfield, where there is an emphasis on developing social skills, five days a week. Four residents attend the Tallaght Welfare Society centre in Glenview for social activities. One attends Eve Holdings in Chapelizod, one attends Stewart's Hospital and one attends a New Horizon centre. None of the residents self-medicate. The rehabilitation executive is considering new assessment tools to be used in the residences.

### UNIT MANAGEMENT

There are no temporary transfers to or from the unit due to bed shortages and there are no crisis admissions. There is central rostering from St. Loman's Hospital. The residence is staffed during the day by a CNM2, a staff nurse, one household staff and one care attendant. At night there is one staff nurse and one care attendant. The waiting list for the residence is managed by the rehabilitation consultant psychiatrist. There is no maintenance programme for the residence and there are long delays for most maintenance problems.

### ETHOS

There is emphasis on rehabilitation and on promoting independence within a homely environment. There is a policy of induction for residents and new staff. There is a range of policies specific to the community residences and work is ongoing on the formulation of new policies. The dress code for staff in the residence is smart casual.

### HOUSE RULES

There are written house rules for the residents, which have been developed by staff in conjunction with residents. There is no smoking indoors. There are rotas for chores within the residence. There is a community meeting every two to three weeks, which focuses on issues to do with the care of the house and mutual respect for residents. Visiting times are flexible. The residents do not have a front door key. Residents are required to check in and out with staff. All except one resident can leave the house

unaccompanied. Residents are required to be out of the house during the day if possible. Residents do not have free access to the kitchen and meals are prepared by staff. Residents are involved in the planning of the meals but not shopping. There are set bedtimes but residents are not expected to get at set times at weekends. None of the residents manage their own money completely. All have post office books and all but two collect their own pensions. Money is kept in the nursing office and residents sign for their money each morning. Most of the residents purchase their own clothes but are accompanied by staff. Some of the residents manage their own laundry. Most residents can access shops, cafes and post office on their own. There is easy access to public transport.

### SERVICE USER INVOLVEMENT

Information on treatment and therapies is usually given verbally by staff. There are some information leaflets available. There is a notice on patient rights and on the complaints policy. There is a community meeting every two to three weeks and a suggestion box is available. There are plans for an independent advocate to visit the residence.

### RECORDS

Clinical notes were in good order and showed evidence of regular review. Residents can access their files. There was evidence that the care plans were reviewed regularly and that progress notes were up to date. The medication sheets were up to date and legible.

### ENVIRONMENT

The residence was clean, nicely decorated, and had a homely atmosphere. The house was not designed as a community residence and there were some difficulties with the layout. Six of the residents were accommodated in three bedrooms at the top of the house. This was a very confined area due to the positioning of the fire door and there was no fire escape. There was a fourth double room and there were two single rooms on the ground floor. The

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dining area was in a room that was formerly used as an oratory and the décor and structure of the room was incongruous. There was a TV lounge, a nursing office, a kitchen, a dining room, bathrooms and toilets. There was a large rear garden but there have been some concerns about the security of the house. There was also a problem with the insulation of the house, resulting in a high cost of heating.

## KILDARE

## BRAMBLE LODGE, NEWBRIDGE

*Date of inspection:* 29th November 2005

*Number of beds:* 14

## DESCRIPTION

This is a 14-bed community residence staffed on a 24-hour basis. There are two respite beds. The premises opened in the year 2000 and is situated on the outskirts of town. It is planned from January that the service will come under the care of the rehabilitation team. On the day of inspection there were seven male and seven female residents.

## REFERRAL

The source of referral is the Acute Unit in Naas and the sector teams. There is an admission policy in existence and patients are only excluded if they are deemed a high risk. Currently the service is managed by the sector teams although in January 2006 the community residence will come under the rehabilitation team. Occasionally people are admitted to the community residence as an alternative to an acute admission and people are regularly admitted for respite care. A referral form is completed and discussed by staff in the community residence. A decision is made by the team whether to admit the patient for respite or for permanent care. On admission the nursing team carry out an assessment and orientate the resident to the premises. The resident is involved in the process of admission and family members are encouraged to have as much contact as possible. The consultant psychiatrist reviews the resident within a week. The initial treatment plan is documented in the nursing and

medical notes, although it was reported an integrated file is being considered.

## CARE PLAN

Care plans are currently nurse led. The care plans identify needs and if other disciplines are needed to meet these needs then a referral is made to the sector team. The nursing care plan is based on goals and objectives. Care plans are reviewed on a regular basis. It was reported that the care plans are discussed with the resident but the resident does not sign them. It was reported that currently there is a fairly static population and there are few lower supported community residence for residents who are ready to move. It was hoped that the new rehabilitation team will support the process of discharge. The service is currently developing a strategy for appropriate discharge and follow on placements.

## NURSING PROCESS

The service developed its own nursing model, which is described as appropriate to the needs of the residents. It is implemented by a key worker and there are some elements of a risk assessment.

## REHABILITATION TEAM

There is access to clinical psychology, occupational therapy and social work input through the sector teams. There is also access to an addiction counsellor. A consultant psychiatrist reviews the residents on a weekly basis.

## INVOLVEMENT IN REHABILITATION PROGRAMMES

There is evidence of needs-based individual programmes. At the present time the emphasis is maintaining the current level of independence and it is hoped that a more structured rehabilitation programme will be developed. Some residents attend services off site.

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**CLINICAL RISK MANAGEMENT**

It was recognised that there is a need to develop individual risk assessments. Serious incidents are recorded on appropriate forms and sent to management.

**UNIT MANAGEMENT**

There are no temporary transfers out of the unit but occasionally, if there is a vacant bed, the acute unit transfers a patient to the community residence. The staff in the community residence are qualified nurses and care attendants. During the day there were two nurses on duty and either one or two care staff. At night there are two nurses, one provided by the acute unit. This is a self-staffing unit apart from the one night nurse who is provided by the acute unit. The residents' physical needs are met by GPs and some residents access the GPs themselves.

**ETHOS**

The ethos of the community residence is to promote independence. There is a formal process of induction for residents and staff and there are appropriate policies and procedure present. The dress code is casual. Maintenance is provided by the hospital maintenance team in Naas.

**HOUSE RULES**

There are house rules regarding smoking, use of alcohol and drugs and respecting other people's space. Visiting times to the community residence are flexible. Residents are allowed to leave unsupervised and they are asked to let staff know when they are going out and what time they will return. Meals are prepared on site by care staff and the residents are fully involved in the meal planning and shopping process. Residents have free access to make drinks and snacks during the day and night. Residents are not required to go to bed at set times and are only asked to be up at particular times in the morning to attend their programme. Residents have a choice with whom they share a room. Some residents collect their own money and manage their own finances, while other residents are supported in looking after

their money. Residents are encouraged to buy their own clothes and are accompanied by staff to the local town. The service appears to be fully integrated into the local community. Residents attend local functions and the local cinema, theatre, bowling club, GAA, sports centre, shops and pubs. Some facilities are within walking distance although it was reported that there is a railway bridge with no footpath that can be dangerous. The unit has its own transport.

**SERVICE USER INVOLVEMENT**

There is a notice board with up-to-date and precise information. Residents have the right to vote. There is a complaints procedure in place which is advertised and there is a suggestion box. There is a weekly community meeting and access to advocacy services.

**RECORDS**

The residents' names and ID numbers were not always evident on the medical notes. Some of the residents have signed a care plan in the past. The entries that are written in the notes have the person's name but not their designation. All entries are signed and dated. There are no progress reports from other health professionals. There is a treatment plan with a medical and nursing component. It was reported that a consultant psychiatrist attends weekly and there are periodic notes in the charts, but no weekly entries. The nursing notes are of a good standard. There is an assessment which leads to a care plan and the care plans are regularly reviewed. Medication cards are all appropriate.

**ENVIRONMENT**

This is a single-storey dwelling situated on the outskirts of Newbridge. There was a good standard of hygiene and decor, and a very high standard of furniture. Most of the bedrooms were double rooms. The premises consisted of single and double rooms, most of which were en-suite. There were two lounges, a large kitchen diner, small kitchen, an office, a laundry room, a garden with a specific smoking area.

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#### STAFF TRAINING

It is hoped that a rehabilitation training programme will be put into place to support the move towards a rehabilitation service. Staff are encouraged to attend in-house training and also to apply for longer courses.

#### GROVE HOUSE, CELBRIDGE

*Date of inspection:* 29th November 2005

*Number of beds:* 14 integrated (6 male, 8 female)

#### DESCRIPTION

Grove House is a 14-bed high support community residence established in 1987. The house caters for residents with enduring mental illness. It is a large detached residence with its own extensive grounds situated on the Ardclough road on the outskirts of Celbridge. Residents range in age from 30 to 72 years. A number of the residents have been here since the unit opened.

#### REFERRAL

Residents are generally referred from Ballydowd House, an assessment and training facility, and are thus known to the service. The consultant psychiatrist overseeing the rehabilitation programme, is familiar with the residents referred to Grove House. Prior to admission to a community residence, a referral and continuing care referral form is completed in addition to a detailed case summary. A Risk of Violence Assessment (ROVA) is also conducted. There are specified criteria for placement in group homes. All assessments are conducted prior to transfer or admission. Residents usually come for a two- or three-week trial at the outset.

#### PROCESS OF ADMISSION

There are a range of policies specific to community residences in this sector service. There is a specific policy on referral and admission to community residences. Residents are generally admitted here for

rehabilitation or continuing care. There are no admissions for respite, or as an alternative to acute admission. There are regular monthly meetings conducted in the house involving the consultant psychiatrist and NCHD. The decision regarding admission takes place at this meeting.

#### CARE PLAN

Care plans are generally completed after six to eight weeks of a trial period although some may come with a care plan from Ballydowd House. Residents are reviewed by the consultant psychiatrist on a regular basis. There is a key worker system in operation. There is a social worker and limited occupational therapy input to the rehabilitation team. There is no psychologist on the rehabilitation team although psychology services can be accessed if requested. A Morningside Rehabilitation Status Scale (MRSS) is completed on every resident and a rehabilitation assessment and six-monthly re-evaluation schedule conducted. The key worker arranges and completes the care plans and re-evaluation schedules. There was documented evidence of these evaluations and reviews. There were no discharges in the last year.

#### NURSING PROCESS

The nursing process is based on the Roper Logan Tierney model, which at the time of inspection was under review. The Tidal model is being piloted in other areas of this service. A ROVA assessment is conducted when deemed necessary.

#### REHABILITATION TEAM

The rehabilitation team consists of a consultant psychiatrist, NCHD and nursing staff. An occupational therapist has recently commenced working but has not been available to date and there is some social worker input. A consultant psychiatrist reviews when requested and there is a meeting in the house every three weeks. Residents in the house are registered with two local GPs and access them independently if they are able to do so.

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**INVOLVEMENT IN REHABILITATION PROGRAMMES**

Residents are involved in individualised programmes to move to lower levels of support. A number of residents attend day services off site in Larine Court in Maynooth and Chapelizod Enterprises both of which are run by Eve Holdings. Staff may accompany residents initially on the journey but they do not attend the day service with them.

**CLINICAL RISK MANAGEMENT**

The HSE Health and Safety Policy was available. ROVA assessments are conducted on individuals when deemed necessary. Incidents are reported on the standard incident and near miss report form used throughout the HSE and this is followed up by the Health and Safety Officer.

**UNIT MANAGEMENT**

There are no temporary or long-term transfers from other units. The community residence is not used for any other purposes. The skill mix consists of two nursing staff on during the day and one at night. There is one care assistant on during the day and at night. In addition there is one household staff five days per week. Unit rostering applies in the community residence. There is a formal process of induction for students and orientation of staff to the clinical area. The rehabilitation consultant psychiatrist manages the waiting list and movements of patients through the service. Maintenance support is provided by Naas General Hospital but is funded by St. Loman's Hospital. This has led to significant difficulties. There is no capital allowance or devolved budget allocated on an annual basis and no maintenance programme in place. The residence clearly had not been refurbished since it opened.

**ETHOS**

The ethos of the community residence is to creating a home-like environment and maximising the individual's personal and social functioning in a supportive, caring and person-centred environment. Staff are of the view that for some patients this is clearly their home and where they should remain.

**HOUSE RULES**

Community residence rules for all community residences in the service apply and these are reviewed when a problem arises. The front door is open throughout the day and residents do not have front door key. Residents are able to lock the toilets but not the bathroom. There was only one single room which the resident was able to lock themselves. The remaining bedrooms were all 3-bed or 4-bed. Residents are allowed to leave unsupervised although they are asked to notify the staff. They are not required to be out during the day. Staff prepare the meals on site and some residents are involved in shopping and meal planning. They participate in setting the table and clearing up. Some residents have free access to the kitchen to make drinks and snacks. The fridge was locked due to the difficulty in managing a particular patient.

Residents are not required to go to bed at set times and not allowed to smoke in their bedrooms. There was only one single room available. Residents as far as possible were facilitated in terms of sharing of bedrooms. There was no room to accommodate a visitor overnight. Residents are not required to get up at set times during the weekend although they are required to be up and dressed at set times during the week. Their belongings are not listed. Residents manage their own finances. Residents have their own disability books, their own ledgers and post office books. One resident had a bank account. Residents have independent access to their own money as required. Occasionally staff will collect money for residents if required. There were written guidelines on the financial management of residents' money. Residents were in receipt of all benefits. They were not asked to pay for new furniture and fittings for the community residence. There was great concern about the pending increase in charges with a lot of upset on the part of the residents regarding the implications of this.

Residents buy their own clothes in the local shops or travel to the local shopping centres. They have free access to the utility room although they do not attend to do their own laundry. Residents are able to access services in the community unaided as they are within walking distance of church, shops and pub. There is good access to a public transport service.

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## SERVICE USER INVOLVEMENT

Information on treatment and therapies is provided on request. Information on rights and other matters was in leaflets on the notice board in the sitting-room. There was information available on national health initiatives. There was a complaints procedure and leaflets regarding this and complaints were followed up. Resident and carer opinions are sought informally. Key workers meet with their own residents – community meetings have been held in the past but have been discontinued due to the perception that they were not working. Advocacy services are being introduced in the service and there are plans to introduce this to the community residence in the near future. Residents were encouraged to vote. Residents interviewed were quite happy with the service and had no specific complaints.

## RECORDS

Case files are kept in the nurses' office. The medical files for two residents who had moved into the unit three months ago had not yet arrived at the community residence. With regard to the medical files that were available, all the entries were dated and signed. However they were not completed using the full name and designation of personnel. There was a treatment plan in the file. There was written evidence of consultant psychiatrist review every six months or so. The NCHD reviews patients prior to the meeting and as required. The resident name and ID number was on all pages of the nursing file. They were legible and tidy. Entries were completed every week or so. All entries were signed and dated. The care plan in use was the rehabilitation assessment and six-monthly re-evaluation schedule and these were up to date. In addition a new care plan was being piloted and had been completed on some residents. The MRSS was also completed. Residents were not on a self-medicating programme. A blister pack system is in use, provided by the local chemist. The nursing staff sign the administration record at the end stating "meds as per pack". The supplies of clozapine are managed separately. Generic names were not used.

## ENVIRONMENT

There is no regular ongoing maintenance programme in place. In common with many staffed residential units, little or no development seems to have occurred since it opened. The ground has become run down and there are huge difficulties with local youths frequenting the grounds, climbing the fire escape, exposing themselves and disturbing the residents and staff. Maintenance is delivered by Naas General Hospital but is paid for by the St. Loman's Hospital service. The décor was poor and rooms were quite cramped. It was difficult to see how 14 residents and staff could comfortably manage in this house. There are significant encroachments on privacy.

The accommodation consists of a large entrance hall downstairs with some comfortable seating. There was a nurses' office that doubled as a TV room and housed the computers for residents to use and belongings that could not be stored elsewhere. To the left of the entrance hall was the kitchen, pantry, dining room and utility room. There was one toilet and wash-hand basin downstairs, which was accessed through the kitchen and utility room. The dining room was used at night for residents who smoke between the hours of 2030h and the following morning and smoke could be smelt in this room. It had previously been used as a smoking room before the regulations came into place. The reception room downstairs was pleasantly decorated with comfortable furniture and a large TV, notice board and leaflets. In addition one of the residents had a set of keyboards there. There was also a piano in the entrance hall. The utility room facilities were reported as being inadequate with the washing machine regularly out of use. Residents are not involved in meal preparation in the dining room. The stairs from the hallway leads upstairs. On one side there are two male bedrooms each with three single beds. In addition there was one single room in which a female resident resided. All these rooms were cramped, with little personal space, and needed refurbishment. There was one shower room, toilet and sink on this side. On the other side there were two further bedrooms, one with three beds and one with four beds and a bathroom with a bath to which a shower unit was fitted. The window sill was rotting. The floor covering was rising in the dining room and there was evidence of cigarette burns.

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## STAFF TRAINING

Staff were satisfied with the level of training provided. Staff have attended the health care providers course, prevention and management of aggression and violence, manual handling and patient handling. Staff were occasionally notified about courses in rehabilitation although they would welcome more training specifically in this area.

## LARINE HOUSE, MAYNOOTH

*Date of inspection:* 29th November 2005

*Number of beds:* 16 integrated

## DESCRIPTION

Larine House is a large detached two-storey period house located in Maynooth town. It is home to sixteen residents ranging in age from 37 to 73 years. On the day of inspection there were 16 residents, thirteen male and three female. The house opened in 1992 as a community residence with 24-hour nursing staff supervision.

## REFERRAL

The community residence is under the clinical direction of a general adult sector team. All new referrals are through the sector team on a referral form. The admissions mainly come from the acute unit in Naas General Hospital.

## PROCESS OF ADMISSION

All admissions are for rehabilitation or continuing care. The vast majority of residents have been resident in the house since it opened. There is no admission policy specifically for this community residence. On occasion, a patient may be transferred from the acute unit due to a bed shortage. A transfer letter and documentation accompanies the resident on admission. The consultant psychiatrist visits fortnightly. A key worker is allocated on admission.

## CARE PLAN

There is no multidisciplinary team input into the community residence. The medical treatment plan is documented in the medical notes. The nursing care plan is documented in the nursing notes. In 2005 there have been four discharges, one to a nursing home and three to independent living. A number of residents attend an Eve Holdings Limited centre, day centres locally and other facilities.

## NURSING PROCESS

There is a newly introduced nursing assessment. This assessment was developed locally and highlights areas of risk that may require further investigation. Nursing and health care assistant staff provide the key worker system.

## REHABILITATION TEAM

A new rehabilitation team will commence work in 2006. At present access to social work and clinical psychology is via referral to the sector team. There is no occupational therapist on the sector team. The consultant psychiatrist visits regularly. The NCHD completes the six-monthly physical examinations. All residents are registered with a local GP. The community residence is staffed during the day by a CNM2 and two staff nurses. There is also a domestic staff and health care assistant on duty. At night one staff nurse and one health care assistant are on duty.

## INVOLVEMENT IN REHABILITATION PROGRAMMES

Residents attend programmes outside the house. Eve Holdings Limited have a resource centre next door to the community residence. Older residents attend a local centre for the elderly. One resident is involved in a community employment scheme.

## CLINICAL RISK ASSESSMENT

There is no formal clinical risk assessment in place. The nursing assessment forms contain a brief risk assessment history. All incidents are recorded on the HSE incident report form.

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#### UNIT MANAGEMENT

Nursing, health care assistants and household staff members staff the community residence. All staff are rostered locally and are on a two-year rotation. The ethos of the community residence varies according to the residents' needs. Beds have been used in the past to alleviate a bed crisis in the acute unit. The general hospital provides maintenance for the building. The building is old and requires regular ongoing maintenance. The community residence is guided by service-wide policies and procedures. There are no policies specific to the community residence.

#### HOUSE RULES

There are house rules and a resident is informed of these on admission. Visiting time is open. Residents do not have a front door key, however they can lock the bathroom door. Meals are prepared on site by all staff groups. Residents participate in menu choice. There are no single rooms. There are two 4-bed rooms and two 3-bed rooms, and one 2-bed room located downstairs. A number of residents are independent in managing their own finances while others are given assistance by staff. The recording and accounting for these monies was in order. On the day of inspection, no resident was paying rent. The new rent charges were a source of anxiety for residents interviewed. There is no written procedure or policy in place for the financial procedure in operation. Residents are assisted with shopping for clothes according to need. The community residence and residents are well established in the community and access all facilities.

#### SERVICE USER INVOLVEMENT

Residents are provided with oral information on any treatment by staff. There are regular minuted community meetings. All residents are registered to vote and exercise their right. The Irish Advocacy Network does not visit the house.

#### RECORDS

There were separate medical and nursing notes. There was no evidence of entries from any other

disciplines. The medical notes reviewed showed evidence of regular mental state reviews and physical examinations. The nursing notes contained an assessment, care plan and progress notes. There is a need to update the paperwork and introduce a standard for documentation. It was subsequently stated that there is a nursing documentation standard which has been introduced to all areas. The new rehabilitation team, it was reported, will begin to introduce the Functional Analysis of Care Environment Assessment (FACE) next year. No patient was self-medicating. The card index system was in order.

#### ENVIRONMENT

This is a two-storey detached house. The interior and exterior require painting. Due to the age of the building ongoing maintenance work is required. The house is not lifetime adaptable and given the ageing resident group will present a challenge in the near future. The downstairs en-suite is to be upgraded and increased in size. There was a sitting room, office, kitchen and dining area downstairs. There was an external smoking shelter in the garden. New furniture for the sitting room had been ordered. The toilet areas needed to be upgraded. The showers were narrow and not suitable for the residents.

#### STAFF TRAINING

Staff are offered training in mandatory courses. These are provided in-house by nursing staff. Nurse student placements are facilitated in the community residence.

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## COMMUNITY CARE AREAS 4 AND 5

### ST. COLUMBA'S COMMUNITY RESIDENCE, CRUMLIN

*Date of inspection:* 29th November 2005

*Number of beds:* 20 integrated

#### DESCRIPTION

St. Columba's community residence was previously a Christian Brothers residence. The community residence is situated on the first floor of the building; the ground floor is used by the Crumlin Day Hospital. The building is large and has security on the ground floor. The main focus in the community residence is on continuing care. The age range of patients is from 38 to 72 years.

#### REFERRAL / PROCESS OF ADMISSION

Most of the patients in the community residence are long stay. All referrals are to the consultant in rehabilitation who assesses the client. The referral is then discussed at the multidisciplinary team meeting. The client is assessed by nursing staff in the community residence and visits the community residence with his or her family or carer.

#### CARE PLAN

A multidisciplinary care plan is being developed through the rehabilitation team and community residence committee. In the meantime the Roper Logan Tierney model is used, which staff feel is inappropriate for the client group. Residents are currently being assessed through the Morningside Rehabilitation Scale which is reviewed annually and through the ELSIE, which is reviewed every month.

#### NURSING PROCESS

There are two nurses and one care assistant on duty during the day and one nurse and one care assistant on duty at night. There is one household staff member on duty during the day. The Assistant Director of Nursing for the community residence is

based in the community residence. There is a key worker system in operation with a nursing staff and care assistant for each group of patients, although there are difficulties with continuity of staff. Two staff members are learning sign language to communicate with two residents who are deaf.

#### REHABILITATION TEAM

There is a rehabilitation team with responsibility for the community residence. Surprisingly, some of the community residence residents remain under the sector teams. This means that the nursing staff are communicating with three or four sector teams and their outpatients departments (where separate clinical files are maintained) as well as the rehabilitation team. Understandably this had led to communication difficulties between staff and treating teams. The staff did not know the reasons for this division of clinical responsibility and stated that they would prefer if all residents were under the rehabilitation team. There are monthly team meetings in the community residence attended by the social worker, Assistant Director of Nursing, NCHD and nursing staff. There is no psychologist or occupational therapist with input to the unit or who attend team meetings. It was stated that patients are reviewed at these team meetings but there was no evidence of this in the clinical file. All residents attend a local GP for their medical needs.

#### INVOLVEMENT IN REHABILITATION PROGRAMMES

Most of the residents attend activities in day centres or resource centres. About six residents remain in the community residence during the day. There is an active re-socialisation programme for these residents and the staff are currently looking for funding for further activities for these clients. A recent art project with an art therapist resulted in a successful exhibition and had the added benefit of engaging families of residents and local community with the residents and staff.

#### UNIT MANAGEMENT

There is a community residence committee that meets regularly. There are no crisis admissions or

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respite admissions to the community residence. There is one resident waiting for discharge to lower levels of supervision. Medication is obtained from a central pharmacy. Residents access the local shops and hairdressers and some use public transport. All residents receive benefits, which are collected by staff, although there is a plan to have these benefits paid directly into residents' bank accounts. Residents have their own bank accounts and fund in the community residence and can access their money when they wish. It was stated that there are ongoing difficulties with maintenance for the unit.

### HOUSE RULES

There is a list of house rules that are reviewed occasionally with residents. Patients do their own personal shopping, accompanied by staff if necessary. Shopping is delivered to the unit and meals are cooked on the unit in the evening and at weekends. There is a rota for chores for each resident. One resident has a key for her bedroom.

### SERVICE USER INVOLVEMENT

There is a user group recently set up that is being facilitated by the local Mental Health Association. There are leaflets about the service available and there is a complaints policy and procedure.

### RECORDS

The clinical files inspected showed no evidence of regular psychiatric review and in some cases there was no documentation of any review for two years. The medication sheets were up to date, signed and legible. The care plans were satisfactory and showed evidence of regular review. As stated previously, patient reviews take place at outpatients and clinical documentation is held at the outpatients department.

### ENVIRONMENT

The community residence was on the first floor of a large building. It was very clean but required re-decorating. The bedrooms were either single or

double rooms and had personal possessions. A large sitting room that was used as a smoking room was filled with smoke, although there was an extractor. There was also a small sitting room with a TV. There was a pleasant sitting area at the top of the stairs. The kitchen was satisfactory. The dining room was brightened by paintings done by patients. The community residence required painting throughout as it was dull and gloomy. There was no heating in the only shower in the community residence which rendered it unusable.

## CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

### WARRENTOWN HOUSE

*Date of inspection:* 31st January 2006

*Number of beds:* 8

### DESCRIPTION

Warrentown House is an in-patient facility for Child and Adolescent Mental Health Services. The unit is an old period house situated near Blanchardstown in Dublin. There are eight in-patient beds currently, but it was stated that this could include a further four day places if staffing levels were increased. There were a total of 35 admissions in 2004 and the age range of admissions was between 8 and 15 years. The mean length of admission is 40 days. Because of shortages of staff, the unit only offers a five day service. Children are admitted for a wide variety of reasons, including management of risk, diagnostic clarification, assessments, specific treatments and commencement of medication.

### REFERRAL

While most referrals are from the HSE South Western Area, a significant number of referrals come from different parts of the country, due to the lack of child and adolescent in-patient facilities countrywide. Referrals can only be made by child and adolescent consultant psychiatrists. A referral form is completed for each referral. Emergency referrals are processed immediately, while less urgent referrals are discussed at a weekly multidisciplinary team meeting. As the

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unit is open, risk assessment reports form an important part of the referral process.

### PROCESS OF ADMISSION TO THE UNIT

Following acceptance of the referral, children initially visit the unit for a day prior to making a decision to be admitted to the unit. During this time they meet with staff and are usually assigned a key worker and the initial needs-based assessment is commenced. Parents or guardians also meet with staff at this time. Following admission all children have a physical examination and routine investigations. There is an emphasis on family involvement from the time of admission.

### CARE PLAN

Each child has an individual multidisciplinary care plan. Children and family or guardians are actively involved in the care plan. There is a weekly multidisciplinary meeting once a week to review resident children. There is continued liaison with the referring team and there is a case conference prior to discharge, involving the team to which the child is being discharged. A detailed discharge report is sent to the referring team. Occasionally a child may continue to attend as a day patient for short periods of time or, alternatively, discharge may be on a phased basis. There are occasional difficulties in referring children on to adult services at the age of 16 years, which may result in an increased length of stay.

### ACCESS TO THERAPY

Where possible, the children attend school from 1000h to 1500h. There are two teachers in the school attached to the unit, who offer a primary and post-primary programme including examination preparation. There is a requirement for a classroom assistant. Activities after school include a mixture of leisure and group or individual therapy and there is a sensory room for relaxation. There are two consultant psychiatrists, working one whole time equivalent, and there is a social worker who is also a family therapist. There are a number of unfilled vacancies for psychology (0.5 whole time equivalent) and a speech and language therapist (0.5 whole time equivalent)

as well as four vacant nursing posts and two clinical nurse specialist posts. There is access to community clinical psychologists and speech and language therapists in the HSE South West Community Child and Adolescent Mental Health Service, if there is an urgent requirement.

### NURSING PROCESS

There is a CNM1 and CNM2 as well as four nursing staff and three child care workers. There are two staff on duty at night. There is a key worker system in operation. There are three observation levels (General, Grade 1 and Grade 2) in the unit, which may be commenced by nursing staff but must be discontinued by medical staff. Grade 1 observation is where the child is in view of the staff and hourly records are kept. Grade 2 observation is one-to-one nursing at arm's length, usually the child is in night clothes and in his or her bedroom and 15-minute checks are recorded.

### SECLUSION

There is no seclusion or Time Out carried out on the unit. Children are never locked into any room.

### CLINICAL RISK MANAGEMENT

Each child has an individual risk assessment as part of their care plan. All policies were available on the unit including a smoking policy. All nursing and care staff are trained in therapeutic crisis intervention and all staff are trained in life-saving skills and go through a formal induction process.

### UNIT MANAGEMENT

The unit is an open unit. It provides a five day service. On occasion it remains open at the weekends if there is an urgent need or alternatively children may be transferred to a paediatric unit for the weekend. Meals are cooked on site. There are 3.5 whole time equivalent household staff in the unit. Family visits are actively encouraged. There is CCTV on the corridors and a movement sensor on the corridors at

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night. Mobile phones are not allowed but there is a private phone area.

### RECORDS

The clinical files were up to date and were in good condition. The care plans were well maintained and current. Medication sheets were satisfactory.

### ENVIRONMENT

The unit is pleasantly decorated and is homely and comfortable. There are six bedrooms upstairs. Children are encouraged to bring personal possessions and their own bed clothes. There is a dining room that doubles as a pool room. There are two sitting rooms, the larger room serving as a multi-purpose room, and an art therapy room. The large staff room is also used as the library and conference room. At the back of the unit there is a two-classroom school and outside basketball court. However there is neither an indoor game or PE facility nor outside playground equipment.

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## RECOMMENDATIONS

### KILDARE

#### LAKEVIEW ACUTE UNIT, NAAS

1. Each sector should have a full multidisciplinary team.
2. The plan to introduce multidisciplinary care planning should proceed without delay.
3. Patients from the admission unit should not sleep in hostel accommodation because of bed shortages in the acute unit.
4. There should be access to advocacy services for patients in the acute unit.
5. All prescriptions should be signed, dated, legible, with discontinuation of medication signed and dated.

### COMMUNITY RESIDENCES

#### OVERALL RECOMMENDATIONS

1. The rehabilitation team should be fully resourced with occupational therapy, social work, psychology and outreach nurses.
2. All 24-hour supervised residences should be under the care of the rehabilitation team.

#### LARINE HOUSE

1. Essential maintenance should be carried out and there should be an ongoing programme of maintenance for the unit.

#### GROVE HOUSE

1. Essential maintenance should be carried out urgently and there should be an ongoing programme of maintenance for the unit. The grounds of the residence should be maintained
2. The number of residential places should be decreased to reduce the overcrowding of

sleeping and other areas.

3. Security should be provided prevent antisocial behaviour by youths on the premises

### AREAS 4 AND 5

#### ADELAIDE & MEATH INCORPORATING THE NATIONAL CHILDREN'S HOSPITAL (TALLAGHT)

##### ACUTE PSYCHIATRIC UNIT

1. The plan to continue to replace clear glass windows with tinted windows in the unit and in the seclusion room should be proceeded with to preserve the privacy of patients.

### ST LOMAN'S HOSPITAL

#### ST. JOSEPH'S UNIT

1. As all residents are discharged, they must not be locked into the unit.
2. Each resident should have an assessment for accommodation needs and transferred to appropriate accommodation as soon as possible and the unit closed.
3. There must be basic cleaning and maintenance of hygiene on the unit.
4. Each resident must have regular psychiatric reviews.
5. All nursing care plans must be kept up to date.
6. All residents should have access to therapeutic programmes as part of their individual care plan.
7. All residents must have access to their own money. Residents' money must not be used for unit activities or communal purchases. Each resident must have their own bank or savings account. Residents' money must not be used as a reward for good behaviour without their permission. Any monies taken from residents' finances without their written permission must

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be repaid in full. There must be a written money management policy.

8. Essential maintenance must be carried out.

**REHABILITATION UNIT**

1. The rehabilitation team should be fully resourced with occupational therapy, social work, psychology and outreach nurses.
2. The community residence (Teach Bán) should open as soon as possible to enable patients who are ready for discharge to move to the community.
3. Patients from the acute unit should not sleep in the rehabilitation ward because of bed shortages.
4. The quality of the food for patients should be reviewed.

**COMMUNITY RESIDENCES**

1. Essential maintenance should be carried out urgently and there should be an ongoing programme of maintenance for the unit.

**ST. COLUMBA'S RESIDENCE**

1. All residents should be under the clinical care of the rehabilitation team and the all records pertaining to residents' care maintained in the residence.

**AREA 3****JONATHAN SWIFT CLINIC, ST. JAMES' HOSPITAL****WILLIAM FOWNES WARD (ADMISSION UNIT)**

1. There should be a high observation area to prevent transfer of patients to St. Brendan's Hospital and to allow the unit to be an open unit.
2. Beds of patients who are on leave should not be used for new admissions to the unit.
3. The condition of the entrance to the unit should be reviewed and there should be a dedicated admission area. Basic items such as chairs, security camera and a functioning door lock should be provided.
4. The condition of the clinical files should be improved.

**CONNOLLY NORMAN UNIT**

1. There should be a key worker system in operation in the unit.
2. There should be a designated visitors area.
3. There should be ready access to a garden or outside space for patients.

**BECKETT UNIT**

1. There should be an admission and transfer policy for this unit.
2. Each patient should have an integrated care and treatment plan that contains a social, psychological, occupational, nursing, psychiatric and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There

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must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated by the patient's key worker.

3. The standard of the nursing care plans should be improved.
4. The function of this unit is unclear. Patients requiring continuing care should be transferred to supervised community placement. Those requiring rehabilitation should be under a multidisciplinary rehabilitation team. Patients requiring acute care and patients who are detained should be treated in the admissions unit.

## COMMUNITY RESIDENCES

### OVERALL RECOMMENDATIONS

1. There should be a multidisciplinary rehabilitation team with responsibility for the community residences.
2. Each patient should have an integrated care and treatment plan that contains a social, psychological, occupational, nursing, psychiatric and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated by the patient's key worker.

### QUILCA RESIDENCE

1. Each resident should have a key worker.

## CHILD AND ADOLESCENT SERVICES

### WARRENTOWN HOUSE

1. Staffing should be increased to offer further places and to provide care at week-ends.
2. There should be an outside playground area and an indoor games/PE area.

## Chapter 3

Health Service Executive  
Dublin/Wicklow

Dublin/Wicklow

## ST. VINCENT'S HOSPITAL, ELM PARK

### ELM MOUNT UPPER AND LOWER

*Date of inspection:* 27th September 2005

*Number of beds:* 54 beds (20 upper, 21 lower)

#### DESCRIPTION

Elm Mount provides a new service following the amalgamation of the Acute Unit in Vergemount and St. Camillus's Ward in St. Vincent's Hospital. This new facility is one unit comprising of two floors which opened in May 2005. On the upper floor is Acute Admission and on the lower floor is a service for Psychiatry of Later Life (POLL), continuing care beds and an eating disorder service. There is also provision for liaison and mother and baby service.

#### REFERRAL

The unit is still trying to define the admission process between the two wards. Currently the sources of referral to the upper floor are the sector teams, outpatients, GPs., A&E and other hospitals. The lower floor sources of referral are the POLL team, the eating disorder service, and transfer of patients from the upper floor and the liaison service.

#### PROCESS OF ADMISSION

People under the age of 16 years or people with a moderate intellectual disability are not admitted. People with a dual diagnosis may be admitted for detoxification where necessary. Within both areas, new admissions receive a full mental state assessment and a nursing assessment. In the acute area on the upper floor, there is a key worker system, on the lower floor there is a team nursing system. Each of the admission assessments contains a physical examination and a collateral history. Communication to the patient regarding the admission process is facilitated by the admitting nurse and doctor on the day of admission and the patient is orientated to the unit. Contact is made with family wherever possible. The consultant psychiatrist reviews the patient within 24 hours. In the admission area there is a night

clothes policy, but not all new admissions are nursed in their night clothes; each patient is assessed individually. There are two levels of observation, special and general.

#### CARE PLAN

Care planning on the unit differs between the two floors. On the upper floor, the nursing care plans are incorporated into the multidisciplinary team plan. On the lower floor, the care plans are nurse led in conjunction with the medical staff. There is a referral system to occupational therapy, social workers and psychologist. Care plans are reviewed depending on need. All patients participate in the process but there is no documented participation by the patient in the care plan, other than in the eating disorder service. In the eating disorder service, there are specific contracts drawn up with patients. Discharges from the service are on a planned basis and are discussed at the multidisciplinary team meeting. It is apparent that there are two care planning systems currently running within this unit.

#### NURSING PROCESS

On the upper floor, the nursing staff use the Orem model of nursing which they have adapted. On the lower floor, they use the Peplau model of nursing. Both are described as appropriate to need and are nurse led. There are elements of risk assessment in each of the models and the practices on the ward. There is a key worker system on the upper floor and a team nursing system on the lower floor. The dress code on the unit is linked to the general hospital dress code.

#### ACCESS TO THERAPY

It was noted that there are new staff from different clinical backgrounds. Currently there is referral to psychology, occupational therapy and social work services. The lower floor has access to an art therapist and dietician. There are a number of consultant psychiatrists available to the unit. On the upper floor, there are six general psychiatrists and two POLL psychiatrists who have admitting rights. On

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the lower floor there are four consultant psychiatrists who have access to the beds who incorporate old age, liaison and eating disorders. Generally, consultant psychiatrists review the patients once a week at a minimum. Medical and surgical consultations are through the liaison consultant and there are plans for a general physician to be allocated to the unit.

### ACCESS TO THERAPEUTIC PROGRAMMES

There is evidence of needs-based group therapy on the unit. There are a range of groups available, including art, anxiety management, music, relaxation and a specific programme for the eating disorder patients.

### ECT

There is an ECT policy and procedure in place. The consent forms are appropriate and consent is obtained by the consultant psychiatrist. There is written information on ECT for the patients and there is a nursing procedure and checklist. There is a dedicated ECT nurse and consultant psychiatrist. The ECT suite has a waiting area, preparation room, treatment room and recovery room. The waiting area was of a good standard. Preparation rooms all had appropriate monitoring. The treatment room was single and had appropriate anaesthetic equipment. There was a maximum of three beds in the recovery room, which had all the appropriate monitoring equipment.

### SECLUSION

There are two seclusion rooms within the unit, however they are not currently in use.

### CLINICAL RISK MANAGEMENT

There is a policy on risk management available. There is an alarm system in operation. There are various policies and procedures in place within the two levels of the unit and these need to be combined. The staff are trained in crisis prevention intervention

techniques which include de-escalation and breakaway techniques. All staff receive cardio-pulmonary resuscitation training and other mandatory training. There is an accessible training programme within the hospital and support is given for staff to attend courses. There are no formal clinical risk assessments documented in the patients' charts. Serious incidents are recorded on appropriate forms and sent to nursing administration. Feedback is obtained from the risk management department.

### UNIT MANAGEMENT

There are no temporary or long term transfers to other units. Patients are allowed off the ward. The door is open during the day. Patients who are nursed in their night clothes are not allowed to leave the ward. A clozapine clinic is conducted on the upper floor. There are six staff on duty on the upper floor during the day and three at night. On the lower floor, there are five staff on duty during the day and three at night. All staff are qualified. Staff are rostered permanently to the unit. However it was noted that the staff from the Vergemount Unit are mostly placed on the upper floor and staff from the previous St. Vincent's Unit are on the lower floor. There is some movement of staff within the unit but this needs to continue and expand. There is availability of a ward clerk and a phlebotomist. It was reported on the lower floor that more time from a ward clerk was needed. Maintenance is carried out by the hospital maintenance department. Visiting times are restricted on the upper floor at meal times but open on the lower floor. Meals are at set times and there is availability of snacks and drinks in between.

### SERVICE USER INVOLVEMENT

There is information on treatment, therapies and rights available. There is a HSE-wide policy on complaints which is consistent across both floors. There are regular meetings between the staff and patients on both floors. This is a new initiative on the upper floor and the staff and patients meet twice a week and notes are kept of this. The lower floor staff and patients meet on a monthly basis. There are proposals to have access to advocacy.

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## RECORDS

The patients' names and ID numbers were evident on all pages of the files. The files were legible and tidy. The entries had full names and titles of personnel and were signed and dated. They contained progress reports from allied health professionals if involved.

There was a treatment plan evident which was regularly reviewed and progress reports noted. Frequency of consultant psychiatrist review was a minimum weekly and NCHD contacted daily. The nursing care plans were regularly reviewed. Drug card indexes were signed, dated, legible and used generic names. The chart of a patient treated with ECT was appropriate and the charts for patients who had been involuntarily admitted were appropriate.

## ENVIRONMENT

This was a 41-bed new service recently opened in St. Vincent's Hospital, Elm Park. There are 20 beds on the upper floor and 21 beds on the lower floor. The upper floor is predominantly acute admissions and the lower floor contains services for eating disorders, elderly care and continuing care. The décor of the unit was good and it was noted that there was a need for some pictures and other more comfortable furniture. It was reported that these items will be purchased in the near future. There were a number of quiet areas within the unit. There were plenty of notice boards with current and appropriate information. There were visitors' areas and access to a garden but this was restricted on the upper floor. There was a clearly defined reception area that had a receptionist and minimum barrier levels. There was no defined admission area. New referrals were sent straight to the ward.

The bedroom areas were a mixture of single, double, 4-bed and 5-bed dormitories. Each of the dormitory areas had collapsible curtains around the beds and each person had their own wardrobe space. There were sufficient toilets and bathrooms on both floors but overriding locks were needed on the doors. The dining areas were appropriate for all patients at one sitting and were integrated. There were several exercise and activity areas that contained two group rooms and an art room. The lounge areas contained comfortable seating and appropriate furniture. The unit had access to newspapers, TV, video, radio, books and the décor was of a good standard. The

quiet areas contained comfortable seating. There were interview rooms available, situated in the main corridors of the ward. The doors opened outwards and there were observation panels in the doors. The mother and baby area of the unit was not currently operational.

The nursing stations were situated centrally on both floors. They were open plan with offices behind. There was space for report writing, they were accessible and there was a telephone and IT system. The clinical rooms were situated behind the nurses' station on both floors. Appropriate storage and equipment was in evidence. It was noted that storage for clients' possessions was limited within the unit. There was appropriate storage for money, files, records, medication, catering and linen. The seclusion area was not operational. This consisted of two rooms on the upper level. The walls were smooth and the windows were large with blinds which were controlled from outside the room. The doors had an observation panel and two-way opening and were solid in design. Furniture and fittings for these rooms were on order. The décor was of a good standard and was bright with natural light.

## VERGEMOUNT HOSPITAL

## LE BRUN HOUSE (UNIT D)

*Date of inspection:* 27th September 2005

*Number of beds:* 26 beds

## DESCRIPTION

This unit provides care of the elderly to a group of patients with high dependency mental health needs. On the day of inspection, there were 24 patients, 9 male and 15 female. The unit is locked. Three of the patients are Wards of Court. The Psychiatry of Later Life (POLL) team provides a service to this unit and has admitting rights. The age range of patients was 65 to 90 years.

## REFERRAL

The main sources of referral to this unit are the POLL service for Areas 1 and 2 and the mental health services Area 2.

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#### PROCESS OF ADMISSION

There is a recently revised admission policy for this unit. A full psychiatric and physical assessment is carried out in the community by the consultant prior to admission. The consultant psychiatrist makes the decision to admit. New patients are reviewed by the consultant psychiatrist within a week of admission. A GP sees the new patient on the day of admission. According to staff, there is no key worker system in place but a team of nurses is assigned responsibility for a particular group of patients. It was reported that current staffing levels make continuity of care difficult.

#### CARE PLAN

There is no multidisciplinary care planning system in place. Care plans are nurse led. Following a nursing assessment, goals and objectives are set and these are reviewed weekly. Family meetings take place approximately every three months.

#### NURSING PROCESS

Staff reported that the nursing model in use is the Nursing Care Dependency Model. It contains a risk assessment. No individual key worker system is in place and there are no levels of observation. Staff wear name badges and female staff wear uniforms.

#### ACCESS TO THERAPY

Patients can be referred to a psychologist or social worker but there is no occupational therapist in the service. A physiotherapist visits twice weekly. The consultant psychiatrist visits the unit weekly. A GP visits the unit daily Monday to Friday. Medical and surgical consultations are organised by the GP or NCHD in one of the nearby hospitals. Lab and X-ray results can take up to a week to arrive.

#### ACCESS TO THERAPEUTIC PROGRAMMES

There is needs-based individual and group therapy. A nurse is employed full-time to provide a therapeutic service to Units D and E in Vergemount and to

Coiscéim unit. Activities include reminiscence therapy, Sonas therapy, multi-sensory work, aromatherapy, reflexology and relaxation groups. It is difficult for one therapist to provide a service to 77 patients and there are further difficulties as there is no cover when this therapist is on leave.

#### ECT

No ECT takes place on this unit.

#### SECLUSION

There is no seclusion room on this unit and no-one is secluded.

#### CLINICAL RISK MANAGEMENT

There is a policy on risk management. There is one personal alarm available to staff and a pager connection to the day centre. There are policies on patients going missing, the management of violent episodes, giving medication without consent and searching patients' belongings. There are also policies on mechanical and physical restraint. Seat belts and cot sides and a chair are used when prescribed by the consultant for reasons of safety. Nursing staff receive training in control and restraint techniques, cardio-pulmonary resuscitation and other mandatory training, such as manual handling. Clinical risk assessments are documented in the patients' charts. There is a system in place for reporting and auditing serious incidents.

#### UNIT MANAGEMENT

There are no temporary transfers to or from the unit as it is a de-designated unit. The unit is locked. Some patients are allowed off the unit if accompanied by relatives. CCTV is not used and the unit is not used for other purposes. There is central rostering. There are four nursing staff and two nursing assistants on duty during the day and two nursing staff and one nursing assistant at night. There are two household staff on duty during the day. There is a process of induction for staff. Clerical assistance is available and

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is shared with unit E. Phlebotomy services are provided by the GP or the NCHD. The waiting list for the unit is managed by the consultant psychiatrist. Visiting times are flexible. Meals are at 0900h, 1145h and 1630h. Drinks and snacks are provided at other times. Seven of the patients receive €25 comforts money and a separate list is kept for each.

## SERVICE USER INVOLVEMENT

There are information leaflets available on treatment and therapies and information is also given verbally. Information is available on patients' rights and on the complaints policy. There is a survey of patients' opinions of the service and meetings with relatives. There are plans to start a Family Support Group shortly. There are no community meetings but it is reported that there is access to a Regional Advocacy Service.

## RECORDS

The medical files contained the patients' name on all pages and were legible and tidy. Entries were signed and dated but did not always have the full names and titles of personnel. There were medical progress reports but no reports from other professionals. There was a medical treatment plan and weekly medical review. The nursing files had the patients' name on all pages and were legible, tidy and had up-to-date care plans. A daily record is kept in each file. The medication sheets were signed, dated and legible.

## ENVIRONMENT

Accommodation in Unit D comprised four 4-bed rooms and 10 single rooms. The outside of the building needed to be painted. New curtains and bed surrounds were also required. There was a large day room with TV but this room seemed quite cramped. There was a quiet visitors' room and an activity room. There was no smoking within the building. The reception porch had an array of leaflets. There was access to a very pleasant garden which was shared with Unit E. There was an assisted bath and one shower, which needed to be upgraded. The dining area had space for one sitting. The nursing office was

the only room available for interviewing patients. There was a clinical room which had all necessary equipment and procedures are carried out there.

## VERGEMOUNT HOSPITAL

## WHITETHORN HOUSE (UNIT E)

*Date of inspection:* 27th September 2005

*Number of beds:* 26 beds

## DESCRIPTION

This unit provides a mix of care of the elderly and continuing care for people under 65 years with mental health problems. On the day of inspection there were 26 patients, 9 male and 17 female. The unit is locked. Three of the patients are Wards of Court. There are two consultant-led teams, including the Psychiatry of Later Life (POLL) team, providing a service to this unit.

## REFERRAL

The main sources of referral to this unit are the POLL service for Areas 1 and 2 and from the mental health service Area 2.

## PROCESS OF ADMISSION

There is a recently revised admission policy for this unit. A full psychiatric and physical assessment is carried out prior to admission. The consultant psychiatrist makes the decision to admit. New patients are reviewed by the consultant psychiatrist within a week of admission. A GP sees the new patient on the day of admission. Staff reported that there is no key worker system in place but that a team of nurses is assigned responsibility for a particular group of patients. It was reported that current staffing levels make continuity of care difficult.

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#### CARE PLAN

There is no multidisciplinary care planning system in place. Care plans are nurse led. Following a nursing assessment, goals and objectives are set and these are reviewed weekly. Family meetings take place approximately every three months.

#### NURSING PROCESS

The model of nursing in use is the Nursing Care Dependence Model. It contains a risk assessment. There are no levels of observation. Staff wear name badges and female staff wear uniforms.

#### ACCESS TO THERAPY

Patients can be referred to a psychologist or social worker but there is no occupational therapist in the service. A chiropodist visits twice weekly. A physiotherapist visits twice weekly. Both consultant psychiatrists visit the unit on a weekly basis. A GP visits the unit daily Monday to Friday. Medical and surgical consultations are organised by the GP or NCHD in one of the nearby hospitals. Laboratory results and X-ray results can take up to a week to arrive.

#### ACCESS TO THERAPEUTIC PROGRAMMES

There is needs-based individual and group therapy. A nurse is employed full-time to provide a therapeutic service to Units D and E in Vergemount and to Coiscéim unit. Activities include reminiscence therapy, Sonas therapy, multi-sensory work, aromatherapy, reflexology and relaxation groups. It is difficult for one therapist to provide a service to 77 patients and there are further difficulties as there is no cover when this therapist is on leave.

#### SECLUSION

There is no seclusion room on this unit and no-one is secluded.

#### CLINICAL RISK MANAGEMENT

There is a policy on risk management. There is one personal alarm available to staff and a pager connection to the day centre. There are policies on patients going missing, the management of violent episodes, giving medication without consent and searching patients' belongings. There are also policies on mechanical and physical restraint. Seat belts and cot sides and a chair are used when prescribed by the consultant psychiatrist for reasons of safety. Nursing staff receive training in control and restraint techniques, cardio-pulmonary resuscitation and other mandatory training, such as manual handling. Clinical risk assessments are documented in the patients' charts. There is a system in place for reporting and auditing serious incidents.

#### UNIT MANAGEMENT

There are no temporary transfers to or from the unit as it is a de-designated unit. The unit is locked. Some patients are allowed off the unit if accompanied by relatives. CCTV is not used and the unit is not used for other purposes. There is central rostering. There are four nursing staff and two nursing assistants on duty during the day and two nursing staff and one nursing assistant on duty at night. There are two household staff on duty during the day. There is a process of induction for staff. Clerical assistance is available and is shared with unit D. Phlebotomy services are provided by the GP or the NCHD. A hairdresser visits on a weekly basis. The waiting list for the unit is managed by the consultant psychiatrist. Visiting times are flexible. Meals are at 0900h, 1145h and 1630h. Drinks and snacks are provided at other times.

#### SERVICE USER INVOLVEMENT

There are information leaflets available on treatment and therapies and information is also given verbally. Information is available on patients' rights and on the complaints policy. There is a survey of patients' opinions of the service and meetings with relatives. There are plans to start a Family Support Group shortly. There are no community meetings but it was reported that patients have access to a Regional Advocacy Service.

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## RECORDS

The medical files contained the patients' name on all pages and were legible and tidy. Entries were signed and dated but did not always have the full names and titles of personnel. There were medical progress reports but no reports from other professionals. There was a medical treatment plan and weekly medical review. At a recent handover of NCHD duties, all patients were reviewed. The nursing files had the patients' name on all pages and were legible, tidy and had up-to-date care plans. A daily record is kept in each file. The medication sheets were signed, dated and legible but the card index needs to be changed because of loose sheets falling out of the folder.

## ENVIRONMENT

Accommodation in Unit E comprised four 4-bed rooms and 10 single rooms. The outside of the building needed to be painted. There was a large day room with TV and notice board but this room seemed quite cramped. There was a quiet visitors' room and an activity room. There was no smoking within the building. The reception porch had an array of leaflets. There was access to a very pleasant garden, which was shared with Unit D. There was one bathroom, which had an assisted bath, and there was one shower room, which according to staff, needed to be upgraded. The dining area had space for one sitting. The nursing office was the only room available for interviewing patients. There was a clinical room, which had all necessary equipment and procedures are carried out there.

## AREA 2

## COISCÉIM UNIT

*Date of inspection:* 27th September 2005

*Number of beds:* 28 (3 respite)

## DESCRIPTION

Coiscéim unit is a two-storey building in the grounds of Area 1 headquarters in Dun Laoghaire, which was opened as a community-based psychiatry of old age unit in the early 1990s. The building is owned by the

HSE and was a former convent and chapel. On the day of inspection, there were 24 patients, seven male and 17 female. This is a locked unit. Four of the patients were Wards of Court. Twenty four-hour nursing care is provided to the patient group, many of whom have dementia or other major mental illness. There is one team with admitting rights to the unit. The age profile of patient was 65 years upwards.

## REFERRAL

Admissions to the unit come from the Area 1 and 2 Psychiatry of Later Life (POLL) service. Respite care is planned with the mental health nursing staff working in the POLL service. Respite admissions often come from their own homes in order to give a period of respite to carers.

## PROCESS OF ADMISSION

The admission policy is similar to that in Units D and E in Vergemount Hospital. There is a recently revised admission policy for these units. A full psychiatric and physical assessment is carried out prior to admission. The consultant psychiatrist makes the decision to admit. New patients are reviewed by the consultant psychiatrist within a week of admission. A GP sees the new patient on the day of admission. There is no key worker system in place but a team of nurses is assigned responsibility for a particular group of patients.

## CARE PLAN

There is no multidisciplinary care planning system in place. Care plans are nurse led. Following a nursing assessment, goals and objectives are set and these are reviewed weekly.

## NURSING PROCESS

The Nursing Care Dependency Model of nursing is in use. It contains a risk assessment. No individual key worker system is in place and there are no levels of observation. Staff wear name badges and female staff wear uniforms.

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#### ACCESS TO THERAPY

The POLL service provides input to the unit. Patients can be referred to a psychologist or social worker but there is no occupational therapist in the service. The consultant psychiatrist visits the unit on a weekly basis. A GP visits the unit daily Monday to Friday. Medical and surgical consultations are organised by the GP or NCHD in one of the nearby hospitals. According to staff, laboratory results and X-ray results can take up to a week to get to the unit.

#### ACCESS TO THERAPEUTIC PROGRAMMES

A nurse is employed full-time to provide a therapeutic service to Units D and E in Vergemount and to Coiscéim unit. Activities include reminiscence therapy, Sonas therapy, multi-sensory work, aromatherapy, reflexology and relaxation groups. One of the patients attends a day centre two days a week.

#### SECLUSION

There is no seclusion room on this unit and no one is secluded.

#### CLINICAL RISK MANAGEMENT

There is a policy on risk management. There are policies on patients going missing, the management of violent episodes, giving medication without consent and searching patients' belongings. There are also policies on mechanical and physical restraint. Cot sides are used when prescribed by the consultant for reasons of safety. Nursing staff receive training in control and restraint techniques, cardio-pulmonary resuscitation and other mandatory training, such as manual handling. Clinical risk assessments are documented in the patients' charts. There is a system in place for reporting and auditing serious incidents.

#### UNIT MANAGEMENT

There are no temporary transfers to or from the unit. There is unit rostering. Staff reported that there is a CNM2 and three staff nurses on duty during the day

and two nurses and one care staff on duty at night. There are three household staff on duty during the day. CCTV is in operation on the front gate. Dress code for staff is smart casual. There is no clerical support. A GP provides phlebotomy services. Visiting times are flexible. Meals are provided from a HSE hospital. Meal times are 0800h, 1245h and 1645h. Drinks and snacks are provided as patients are not allowed in the kitchen. According to staff, only one of the patients is capable of going out on their own but up to seven could go out if accompanied by staff. Four of the patients can manage their own money.

#### SERVICE USER INVOLVEMENT

Information on treatment therapies is usually provided verbally to patients. There is a complaints policy in place. Patients are registered to vote. There are no formal mechanisms for seeking the views of patients or carers about the service, no community meetings and no advocate visits the unit. There are plans to re-introduce a patient meeting every three weeks.

#### RECORDS

The patients' medical and nursing files were tidy and legible. Patients cannot access their files or write in them. All entries were signed and dated but the titles of personnel were not always used. The files contained the patient's name on the front cover. They contained treatment plans and progress reports. A signature bank was available for nursing staff. There were no entries from psychologists, occupational therapists or social workers. The medication sheets were in good order.

#### ENVIRONMENT

The building was formerly a convent and chapel and seemed quite unsuitable for the purpose for which is now used. The unit was the only building in a complex of HSE buildings that was inhabited at night and there seemed to be potential risk to the safety of any staff or patients who might leave the building at night. The building was quite run down. Many new

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windows were required. The whole building needed to be painted and a comprehensive maintenance programme needed to be put in place. There were bars on some of the windows for safety reasons. Accommodation was provided in seven double rooms and 14 single rooms. There was an assisted bath and a new shower. There was a large dining area in the old chapel. On one side there was a smoking lounge and on the other was a non-smoking lounge. There was a shortage of storage space on the unit.

### MOREHAMPTON LODGE

*Date of inspection:* 28th September 2005

*Number of beds:* 3 male, 8 female

#### DESCRIPTION

Morehampton Lodge is located along Morehampton Road in Dublin. It was opened in March 2004 and is owned by the HSE. In addition to 10 long-term beds, there are also four rehabilitation beds, which are not yet operational. It is also planned to have a respite service in the future. The age range of residents is between 21 and 62 years. At present, three residents are receiving in-patient treatment in the acute unit.

#### REFERRAL

All sectors in Area 2 can refer to the residence. All referrals to the residence are made on a referral form, part of which is completed by the prospective resident. Each referral is discussed at the residence management meeting held once a month.

#### PROCESS OF ADMISSION

All admissions to the residence must first be admitted to the acute psychiatric unit for psychiatric and physical assessment. There are no admissions directly from the community. Prior to admission to the residence, prospective residents are invited to the residence to meet staff and undergo a period of induction. If appropriate, family members or carers also meet staff informally. A contract agreeing to the residence's house rules is signed by the resident prior to admission. Due to some difficulties with the local

residents' association certain exclusion criteria to admission were agreed with local residents: a forensic history, a history of sexual offending or a history of addiction.

#### CARE PLAN

There is an impressive multidimensional care plan in operation in the residence. Each client is assessed under personal health care skills, self-care skills, budgeting skills, health and safety skills, domestic skills and communication and socialisation skills. Each subsection of the assessment is scored and a comprehensive care plan is developed from this, in conjunction with the resident. The care plan is reviewed every three months and an analysis chart is used to rate progress over one year. Each resident spoken to was aware of their care plan.

#### NURSING PROCESS

The nursing staff use the care plan described above in lieu of any nursing model, as this is deemed more appropriate to the needs of the resident. There is a formal induction of new staff coming into the residence and there was a key worker system in operation.

#### REHABILITATION TEAM

There is no rehabilitation team in the service. However, the community liaison psychiatrist has responsibility for the overall running of the residence and is part of the management team. This consultant psychiatrist attends the residence weekly. Residents remain under the clinical responsibility of their sector team and attend outpatient clinics when necessary. Each sector social worker is available to the residents. There is no occupational therapy within the service and access to a psychologist is through referral. Each resident also has a sector community mental health nurse.

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#### INVOLVEMENT IN REHABILITATION PROGRAMMES

It is planned that the four rehabilitation beds will open in the near future. A policy governing the rehabilitation beds has not been decided as yet. Residents do not self-medicate in this residence. Resident are involved in their own daily programmes either within the residence or at day centres.

#### UNIT MANAGEMENT

There are no temporary transfers to or from the residence due to bed shortages in other parts of the service. Nursing staffing during the day consists of one CNM2, one staff nurse and one nursing assistant, with two household staff. At night, there is one staff nurse and one nursing assistant. There is no waiting list in operation. There is an alarm system connected to the local Garda station and there is outside CCTV. There is a residence management team, consisting of the community liaison consultant psychiatrist, the CNM2 and the Assistant Director of Nursing, which meets once a month. The emphasis in the residence is on providing a homely environment coupled with active care planning and rehabilitation.

#### HOUSE RULES

House rules are drawn up by staff and residents sign a contract agreeing to abide by these rules. Residents can lock their own doors from the inside (staff have a master key), but not from the outside. Each resident has locked storage inside their own rooms. Residents can access all local amenities and use public transport. Following agreement with local residents regarding the admission exclusion criteria there have been no difficulties with integration into the local community. Each resident has their own GP.

Residents are involved in a rota for cooking meals, shopping, they do their own laundry and buy their own clothes. Residents their own bank accounts and draw their own allowances. Some residents may need help with budgeting. At present, no resident is paying rent or contributing towards day-to-day running of the residence.

#### SERVICE USER INVOLVEMENT

There are a large variety of leaflets and notices for residents on health issues and information about the local services. There is also information about how to make a complaint. There are weekly meetings between staff and residents where such issues as menu planning, proposed outings and other matters are discussed. Residents chair these meetings themselves.

#### RECORDS

Medical files are kept centrally and were not available on the day of inspection. Medication sheets were in the most part satisfactory although many signatures were illegible. The nursing notes and residents' care plans were in excellent order.

#### ENVIRONMENT

The residence is a two-storey building which has recently been refurbished. The standard of the residence's decor, facilities, furnishings and availability of living space was excellent. There were six large single bedrooms with en-suite bathrooms and ample storage space. There were two double bedrooms, also en-suite, which will be used for the rehabilitation service. The sitting area was large and comfortably furnished with TV, DVD and a large quantity of books. There was also a visitors' room and an alcove for the residents' phone. The kitchen and the dining room were large and homely and there was a utility corridor. There was a very pleasant garden and outside smoking area.

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## SWANLEA RESIDENCE

*Date of inspection:* 28th September 2005

*Number of beds:* 9 male, 5 female

### DESCRIPTION

Swanlea Residence is located on a quiet street in Rathmines in Dublin. It was opened 14 years ago and is owned by the HSE. There are no respite beds in the residence.

### REFERRAL

All referrals to the residence are made on a referral form, part of which is completed by the prospective resident. All sector teams in Area 2 can refer to the residence. Each referral is discussed at the residence management meeting which is held once a month. As there are very few discharges from the residence there are consequently very few referrals.

### PROCESS OF ADMISSION

There are no admissions directly from the community and all admissions to the residence must first be admitted to the acute psychiatric unit for psychiatric and physical assessment. Prior to admission to the residence, prospective residents are invited to the residence to meet staff and other residents and discuss their admission. If appropriate, family members or carers meet staff informally. A contract agreeing to the residence's house rules is signed by the resident prior to admission.

### CARE PLAN

As in other residences in community care Area 2 there is an excellent multidimensional care plan in operation in the residence, which was developed by Newcastle Hospital mental health services. Each client is assessed under personal health care skills, self-care skills, budgeting skills, health and safety skills, domestic skills and communication and socialisation skills. Each subsection of the assessment is scored and a comprehensive care plan is developed from this, in conjunction with the resident. The care plan is

reviewed every three months and an analysis chart is used to rate progress over one year. Residents spoken to were aware of their care plan and its contents.

### NURSING PROCESS

The nursing staff use the care plan described above in lieu of any nursing model, as this is deemed more appropriate to the needs of the resident. Apart from the CNM2, there are some difficulties in continuity of staff and it is considered fortunate to have the same staff for a period of three months. There is a key worker system in place.

### REHABILITATION TEAM

There is no rehabilitation team in the service. However, the community liaison psychiatrist is part of the management team. The liaison consultant psychiatrist attends the residence every week. Residents remain under the clinical responsibility of their sector team and attend outpatient clinics when necessary. Each sector social worker is available to the residents. There is no occupational therapy within the service and access to a psychologist is through referral. There had been an occupational therapy assistant attached to the residence but was not replaced after leaving. Each resident also has a sector community mental health nurse.

### INVOLVEMENT IN REHABILITATION PROGRAMMES

Each resident is involved in their own daily programme according to their care plan either within the residence or at day centres. One resident attends a local resource centre. One resident has his own art studio in a shed in the garden. The staff run regular goal-setting and stress management groups in the residence. There is a pet dog which is looked after by most of the residents.

### UNIT MANAGEMENT

There are no temporary transfers to or from the residence due to bed shortages in other parts of the service. Nursing staffing during the day consists of

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one CNM2, one staff nurse and one nursing assistant, with two household staff. At night, there is one staff nurse and one nursing assistant. There is no waiting list in operation. There is an alarm system connected to the local Garda station. There is a residence management team consisting of the community liaison consultant psychiatrist, the CNM2 and the Assistant Director of Nursing, and this meets once a month. There are also contacts between the staff of the different residences. The emphasis in the residence is on providing continuing care for the residents.

### HOUSE RULES

House rules are drawn up by staff and resident sign a contract agreeing to abide by these rules. Residents can access all local amenities and some use public transport. Resident have their own GPs.

Residents are involved in a rota for cooking meals and shopping; they do their own laundry and buy their own clothes. Most of the food comes from central stores. Some residents require some supervision with these activities. Residents have their own bank accounts and draw their own allowances. Some residents may need help with budgeting. At present, no resident is paying rent or contributing towards day-to-day running of the residence.

### SERVICE USER INVOLVEMENT

There are leaflets and notices for residents on health issues and information about the local services. There is also information about how to make a complaint. There are weekly meetings between staff and residents where such issues as menu planning, proposed outings and other matters are discussed. Residents interviewed praised staff and expressed satisfaction with the residence.

### RECORDS

Medical files are kept centrally and were not available on the day of inspection. The nursing notes and residents' care plans were in excellent order. Medication sheets were in the most part satisfactory, though many signatures were illegible.

### ENVIRONMENT

The residence is a two-storey building which is need of substantial refurbishment. The kitchen is galley style and is too small. There are significant damp patches on the walls near the back door. Most of the furniture in the rooms needs replacing, including the sitting room furniture. The dining room chairs are mismatched and shabby. There is an activation room with a pool table, computer and games and a quiet room. There are two toilets and two bathrooms and one extremely small shower. There are four triple bedrooms and one double bedroom. New beds have been ordered by staff. There was a small nursing office.

### CLUAIN MHIURE SERVICES

#### OROPESA RESIDENCE

*Date of inspection:* 26th September 2005

*Number of beds:* 21 integrated (15 male, 6 female)

#### DESCRIPTION

Oropesa Residence is a 21-bed purpose-built residence located at the back of a nursing home off the Stillorgan dual carriageway. It was opened in 1998. The bed complement includes one respite bed and one dedicated bed for clients undergoing medication changeover. There are five residents with a significant learning disability in the residence. There is a strong emphasis on rehabilitation and clients are aware that they are on short term placement in the residence. There have been approximately 45 admissions to the residence over the past year.

#### REFERRAL / PROCESS OF ADMISSION

All referrals are through the adult clinical teams. There are four clinical teams and each team retains clinical responsibility for the residents from the relevant sector within the residence. A standardised referral form is completed for each referral. Residents are assessed prior to admission.

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### CARE PLAN

There is a care plan for each resident with three-monthly review dates. However, the format of the care plan is not standardised. Each care plan is the responsibility of the residents' key workers. Although it was stated that residents have input into their care plans, there is no documented evidence of this in the care plans. There are also three-monthly family meetings with the resident and their carers, key workers and social worker. There are ongoing difficulties in moving residents on to low supported accommodation or independent accommodation due to the lack of support and outreach teams in the community, as well as lack of suitable housing.

### NURSING PROCESS

There was no nursing model in operation in the residence. There was a comprehensive key worker system in operation, each client having a nurse and care officer as key workers. All residents were aware of their key workers. There is one nurse manager, four staff nurses and four senior care officers on duty during the day, as well as one staff nurse in the Crannóg day centre nearby and one social care officer who provides one-to-one work with a resident with learning disability. There is also a 0.5 whole time equivalent household staff provision. Two members of staff had completed a challenging behaviour course.

### REHABILITATION TEAM

There is no rehabilitation team in the service and the clinical team retains clinical responsibility for its clients in the residence. There are three-monthly team meetings where all residents from the relevant sector are discussed. The team meetings are attended by the social worker and psychologist. There is no occupational therapist on the clinical teams.

### INVOLVEMENT IN REHABILITATION PROGRAMMES

Each resident has their own rehabilitation programme. Residents attend Burton Hall Rehabilitation Centre, day centres and training workshops. Each resident also has a programme

within the residence which includes such areas as personal hygiene, socialisation and cookery.

### UNIT MANAGEMENT

There are no people sleeping in the residence due to bed shortages elsewhere in the service. There is a mixture of nursing staff and social care workers in the residence and there is unit rostering. Each resident has a key to their own bedroom. Residents have their own bank accounts and as far as possible manage their own finance. The resident can choose whether to contribute financially to residence activities and outings. While any urgent maintenance problem is dealt with, staff reported some difficulties in ongoing programmes of maintenance such as repainting. There was no policy on complaints available in the residence on the day of inspection but there was a patients' charter displayed. The Inspectorate was later informed that the complaints policy is called The Resolution of Patient Concerns and forms part of the residential rehabilitation programme policy documents.

### HOUSE RULES

Each resident signs a contract agreeing to abide by the residence rules prior to being accepted into the residence. Residents can come and go from the residence as they wish. Residents are responsible for their own laundry.

### SERVICE USER INVOLVEMENT

There are weekly group meetings with the residents where issues pertaining to the residence management are discussed. The residents cook their own meals at weekends. They are not involved in regular shopping for food. Residents are actively encouraged to access the community facilities and use public transport. All residents spoken to were pleased with the care they received. They were familiar with their key worker and were aware that they had a care plan. Residents have their own GPs.

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## RECORDS

Clinical files are kept in the Cluain Mhuire headquarters. Each resident has a care plan file. All care plans were up to date but were not in standardised format. Each file also had a descriptive assessment form, a typed report of case review meetings, a copy of the referral forms, a case summary and any multidisciplinary assessments that have been carried out. The medication prescriptions were printed and there was a system in place to ensure that medications must be re-prescribed every six months. Discontinuations of medications were not signed and dated by medical staff, which is unacceptable.

## ENVIRONMENT

The residence was a bright, pleasant building in need of some redecoration and repainting. There was an entrance hall overlooked by the nurses' office. The office was spacious and has plenty of storage space. The unit was a two-storey L-shaped building. All bedrooms are single with en-suite rooms. There are four bedrooms downstairs. All bedrooms are personalised with TVs and had plenty of storage space. There was also an on-call button in each room. One of the single rooms downstairs was fully adapted for persons with a physical disability. There were two sitting rooms and a coffee dock to which there was free access. There was a large, bright dining room that was also used for larger groups and leisure activities such as table tennis. The kitchen was adequate. There was a laundry room with a washing machine and dryer.

## NEWCASTLE HOSPITAL

## AVONMORE

*Date of inspection:* 28th September 2005

*Number of beds:* 30 beds

## DESCRIPTION

This unit is described as a long-stay continuing care unit for 30 elderly residents. On the day of inspection, there were 27 patients, 15 male, 12 female. The unit is locked for safety reasons. On the

day of inspection there were two patients on Temporary status.

## REFERRAL

The main sources of referral to this unit are sector teams, hostels, nursing homes, GPs, the admission unit and a local geriatrician. The consultant psychiatrist carries out an initial assessment. It was noted that there was no dedicated consultant psychiatrist or team for Psychiatry of Later Life (POLL).

## PROCESS OF ADMISSION

There are people with a moderate intellectual disability admitted. People are no longer admitted for detoxification and there was a policy in place to ensure this does not happen. Patients are rarely admitted due to social crisis. A full psychiatric assessment is carried out if there is a direct admission. If it is a transfer from another part of the service, relevant information is already available.

## CARE PLAN

The care plans are nurse led and pertain to physical needs. Physical needs are identified and appropriate goals and objectives are established. Care plans are reviewed on a regular basis. The principal form of discharge from the unit is transfer to nursing homes.

## NURSING PROCESS

The nursing model used was described as an eclectic model incorporated in Newcastle Hospital based on the Roper Logan Tierney, Orem model, Roy's and Peplau models of nursing. It is described as appropriate to the needs of the patients and implemented by the nursing staff. There are some elements of a risk assessment contained in the model, in particular a risk assessment regarding the use of cot sides.

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**ACCESS TO THERAPY**

There is minimal access to psychology input. There is no access to occupational therapy and it was reported that there are no occupational therapy staff due to the staffing embargo. Patients have access to activity programmes within a local enterprise centre and some activities on the unit. There are two social workers who are in regular contact with the unit. Three consultant psychiatrists have clinical responsibility for patients in the unit. The patients on the unit also have access to a physiotherapist and a chiropodist.

**ACCESS TO THERAPEUTIC PROGRAMMES**

There is evidence of some needs-based group therapy. The types of groups available are reality orientation, music, gardening, relaxation, Sonas and the snoezelen room.

**ECT**

There is an ECT policy and procedure in place. Patients from this unit rarely have ECT. If a patient does require ECT, a consultant psychiatrist obtains the consent and also obtains an independent second opinion. There is written ECT information for the patient and there is a nursing procedure and checklist.

**CLINICAL RISK MANAGEMENT**

There is a policy on risk management. There is an alarm system in operation and there is a range of policies in place. The policy folder was comprehensive. Nursing staff receive training in crisis prevention intervention techniques and it was reported that the majority of staff are now trained in this technique. The course also incorporates de-escalation techniques and breakaway techniques. The staff are also trained in cardio-pulmonary resuscitation and other mandatory training, such as manual handling. The staff undertake a risk assessment course, a venepuncture course and have access to long courses through an application process. Reporting of serious incidents is on appropriate forms which are sent to the Assistant

Chief Nursing Officer and to a Clinical Directors meeting. It was reported that a CNM3 audits the incident forms and gives feedback to the unit.

**UNIT MANAGEMENT**

There are no temporary transfers from the unit although they regularly receive attendees from the admission ward during the day. Any long-term transfers are to nursing homes. Three of the patients attend occupational therapy within the hospital. The door is locked and it was reported that this was for safety reasons. The unit is used for patients from other wards accessing the snoezelen room. There was also one day patient who attends the unit for dressings to be changed. Staff are provided through a central rostering system. There is a comprehensive process of induction for staff. The dress code is uniform. Maintenance is provided by the on-site maintenance department. Meals are at set times evenly spread out throughout the day. Some of the patients are on special liquidised diets. There is availability of snacks and drinks throughout the day. Visiting times to the unit are open and visitors are encouraged.

**SERVICE USER INVOLVEMENT**

There is information on treatment and therapies available. This is funded by the Friends of Newcastle Hospital. There is also availability of information on patients' rights and a complaints procedure. Complaints are dealt with locally and are followed up appropriately. There is no formal process of obtaining patients' opinions of the service.

**RECORDS**

The medical files contained the patients' names and IDs on all pages and were legible and tidy. Entries had full names and titles of personnel and were signed and dated. There were medical progress reports but no reports from other professionals. There was a medical treatment plan and the frequency of consultant psychiatrist review varied. The nursing files had the patients' name and ID number on all pages and were legible, tidy and had up to date care plans.

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Drug card indexes were signed, dated and legible. A chart of a person who was involuntarily detained was inspected and was satisfactory. Each patient has a routine six-monthly physical examination. The consultant psychiatrists vary their frequency of reviews from daily to weekly. The treatment plans are documented in separate nursing and medical notes. There is no key worker system.

## ENVIRONMENT

This was a 30-bed unit on the ground floor in a psychiatric hospital. There is ongoing maintenance and currently some work is being undertaken within the unit following the last inspection. The lounge area is to be altered to allow for two separate areas with new furniture. There is disabled access. There was plenty of natural light and ventilation. The décor of the unit was generally good although some areas needed repainting. There was access to a sensory garden which was in excellent condition. The bedroom areas afforded as much privacy as possible. There were three single rooms and a number of dormitories with six beds. Each of the bed areas had curtains around them and each patient had an individual wardrobe space. There were adequate numbers of toilets and bathrooms. The dining area had space for one sitting and the majority of the patients were served their meals. The lounge areas had new seats and the patients had access to newspapers, TV, video and radio. There was a snoezelen room within the unit. The nurses' station was situated centrally within the unit and was confidential and had adequate space for report writing. It was accessible and had a telephone system. There was no IT. The clinical room doubled with the office and contained all the appropriate cardio-pulmonary resuscitation equipment. Storage within the unit was adequate. There were no seclusion facilities.

## GLENCREE

*Date of inspection:* 28th September 2005

*Number of beds:* 30

## DESCRIPTION

Glencree Unit is the acute admissions unit for the catchment. It is an open, ground floor unit, which has 30 beds in use. On the day of inspection, there were 21 patients, 8 male and 13 female. Six patients had Temporary status and 15 had Voluntary status. There are three sector teams with admitting rights to the unit.

## REFERRAL

The main sources of referral to this unit are GPs, out patient departments, Loughlinstown Hospital, self-referrals and An Garda Síochána. An NCHD carries out a full psychiatric assessment that includes a physical examination.

## PROCESS OF ADMISSION

There is an admission policy of which staff are aware. Children under 16 years of age are not generally admitted. People with a moderate intellectual disability are admitted. People can be admitted for a period of respite due to social crises. A full psychiatric assessment is carried out by the NCHD if there is a direct admission. The NCHD can make the decision to admit, though a consultant psychiatrist is available for consultation. The NCHD usually informs patients of their initial treatment plans and contacts the family if appropriate. The consultant psychiatrist reviews the patient within 24 hours. New patients are nursed in their night clothes until the consultant decides otherwise and they are observed every 15 minutes or more often if there is cause for concern. On each shift, a primary nurse is allocated on a sector basis.

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### CARE PLAN

There is no multidisciplinary care planning system in place. The care plans are nurse led. Following assessment, goals and objectives are set. The primary nurse has contact with the patient on a daily basis and care plans are reviewed weekly. A risk assessment is carried out and a discharge checklist is in place.

### NURSING PROCESS

The nursing model used was described as an eclectic model based on the Roper Logan Tierney, Orem, Roy's and Peplau models of nursing. It was felt to be appropriate to the needs of the patients. There is an assessment of risk in relation to violent or challenging behaviour. There are three levels of observation: general; prescribed (15-minute, 30-minute or 60-minute checks); and special (one-to-one). Staff wear identity badges and female staff wear uniforms.

### ACCESS TO THERAPY

Referrals can be made to a psychologist. There are two social workers who are in regular contact with the unit. There is no occupational therapist. The consultant psychiatrists visit the unit on a daily basis. Medical and surgical consultations take place at Loughlinstown Hospital and laboratory and X-ray results can be accessed quickly.

### ACCESS TO THERAPEUTIC PROGRAMMES

There are a number of therapeutic groups available to patients on the unit. These include a relaxation group and a group on medication. A number of patients from the unit attend the KEC centre, which is staffed by nurses and is located next to the hospital. It provides activities such as art, relaxation and sewing and knitting.

### ECT

There is an ECT policy in place and there is an ECT suite, which comprises a preparation room, an ECT

room, which doubles as a clinical room, and a recovery room with three beds. The ECT register, nursing procedure and checklist, consent forms and an information booklet for patients were all available. There is a designated ECT consultant and nurse.

### SECLUSION

There is a seclusion room that is used on a regular basis. There is a seclusion register and an observation checklist. The room was clean and had a mural painted on the wall. It was well lit and ventilated. The surface of the walls and floor was hard. There is no access to a toilet and a bottle or commode is often placed in the room. Refractory clothing is almost always used. There is no communication system for patients but the door has an observation panel and CCTV is used.

### CLINICAL RISK MANAGEMENT

There is a policy on risk management. A pinpoint alarm system is in operation. CCTV is used in a 3-bed dormitory near the nursing office. There is a range of policies in place, which have been updated recently. Nursing staff receive training in crisis prevention intervention techniques, which incorporates de-escalation techniques and breakaway techniques. There is mandatory training in cardio-pulmonary resuscitation and manual handling. There is also a risk assessment course and a course in venepuncture. There is a method of reporting and auditing serious incidents.

### UNIT MANAGEMENT

There have been two temporary transfers from the unit to St. John of God and St. Patrick's Hospitals, which can provide a more secure environment. Long-term transfers take place to Avonmore unit and to high support hostels. The unit is open and most patients are allowed off the unit unaccompanied provided they check in and out. The unit is also used for a clozapine clinic on two days per month. There is central rostering. The unit is staffed by a CNM2 and five staff nurses during the day and two at night. There are two household staff on duty during the

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day. Visiting times are flexible but visits are not normally allowed at meal times and after 2100h. Meals are at 0845h, 1300h and 1745h. Drinks and snacks are provided at set times and most of the patients can access the shop. Maintenance is provided by the on-site maintenance department. There is a ward clerk employed full-time.

### SERVICE USER INVOLVEMENT

There is a general booklet on the service and there are specific leaflets on different medication treatments. Information on patients' rights and the complaints procedure is also available. A patient satisfaction survey is undertaken twice a year. Community meetings are held on the unit once a fortnight. There is no access to an independent advocacy service.

### RECORDS

The medical files were legible and tidy and contained the name of the patient concerned on all contact sheets. All entries were signed and dated but did not always have the title of the person making the entry. There were medical progress reports but no reports from other professionals. There was a medical treatment plan and the frequency of consultant psychiatrist review varied. On the nursing files, the patient's name appeared on all pages. They were also legible, tidy and had up to date care plans. The medication charts were in good order.

### ENVIRONMENT

There was no reception area on Glenree unit and no receptionist. The unit comprised one long corridor with rooms on either side. The nursing office was inside the main door and had an interview room beside it. Bedroom accommodation comprised four 6-bed rooms, one 3-bed room and three single rooms. There were sufficient gender specific toilets and bathrooms. There were three interview rooms in total. Staff reported that the unit had not been painted for two years and paint was peeling from the walls in places. There was a large, sparsely furnished day room with a smoking room next to it. At one

end of the unit was a kitchen and a dining room with enough space for all residents at one sitting. At the time of inspection, it was reported by staff that there was a large area of the unit that had six beds that were no longer used and a second similarly sized empty area.

### FITZWILLIAM HOUSE, NEWCASTLE

*Date of inspection:* 28th September 2005

*Number of beds:* 14 (1 respite)

### DESCRIPTION

Fitzwilliam House residence is a ground floor unit in a large building on the campus of Newcastle Hospital. On the day of inspection, there were 11 residents, six male and five female. The building is owned by the HSE and has operated as a residence since 1985. Twenty-four-hour nursing care is provided. There is no rehabilitation team in this catchment.

### REFERRAL

Referrals come from the three sector teams in the catchment. An application form is completed by the sector team and the prospective resident, who may be in the acute admissions unit or one of the low support residences. This is then presented to a monthly Residence Committee Meeting where the suitability of the individual for a residence placement is discussed and a decision is made. Respite is sometimes provided to people who are living at home or who are experiencing a social crisis.

### PROCESS OF ADMISSION

There is an admission policy that outlines the criteria for suitability. Serious mobility problems, risk of suicide or violence and non-compliance with medication are exclusion criteria. A full psychiatric assessment is required prior to admission and the prospective resident is given an opportunity to visit the residence and meet staff and residents. Within 24 hours of admission, an NCHD conducts a physical examination. A key worker is allocated on admission.

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**CARE PLAN**

The care planning process is nurse led. After a settling-in period, a comprehensive assessment is undertaken that focuses on community living skills. Urgent needs are prioritised. The results of the assessment are scored and a performance analysis chart is formulated. The progress of the individual can be plotted over the course of time using this method. Goals and objectives are set for the resident and these are reviewed periodically. An update of the resident's progress is given by a residence staff member at the various sector team meetings. There were five discharges from the residence during the past year. Staff reported that of the current resident group three residents would be suitable for nursing home placements and five for lower support accommodation.

**NURSING PROCESS**

The nursing model in use was described as the Community Residential Model, which focuses on community living skills. It was felt to be appropriate to residents' needs. A risk assessment is carried out on all residents. Staff wear identity badges but do not wear uniforms. Dress code is smart casual. A key worker system is in operation.

**REHABILITATION TEAM**

There is no rehabilitation team input into the residence but there is some involvement from psychology and social work services through the sector teams. Staff reported that, as the residents are discharged, they are seen by the consultant psychiatrist as and when necessary.

**INVOLVEMENT IN REHABILITATION PROGRAMMES**

There is a range of programmes within the residence that focus on personal health and self-care, budgeting, domestic skills and communication and socialisation skills with the aim of assisting the resident to move to a lower level of support. Residents attend services off site as well. These include KEC, Rehab, Connect and the Lincara Day Hospital in Bray.

**UNIT MANAGEMENT**

There are no temporary transfers to or from the residence. One of the residents sleeps out at night in the Avonmore Unit in the hospital. There is central rostering and there are two nurses on duty during the day and one at night. There are two household staff on duty during the day. The building is used for other purposes. The day room is used for AA meetings. The mortuary and chapel for the hospital are located here and there is a staff dining room located close to the residence.

**ETHOS**

The ethos of the residence is the provision of a homely atmosphere for residents and the development of each resident's potential for independent living. The residents' level of satisfaction is measured formally every three months when the care plan is being reviewed, and informally at other times. A unit profile gives useful information to new staff and residents. A waiting list is operated by the Residence Committee.

**HOUSE RULES**

The rules of the residence have been designed by the staff. Visiting times are flexible. Residents are allowed out unsupervised but are required to check in and out. The policy is that all residents should be out during the day. Residents have free access to a kitchenette for drinks and snacks. Meals are prepared in the hospital kitchen and residents are unable to take part in planning the meals or shopping for them. Residents are required to get up at certain times at the weekend. No smoking is allowed within the residence. Residents are not required to go to bed at a certain time. There is no specific money management policy in place. Residents' money comes to the general office in the hospital and deductions are made. No statements are sent to the residents. Two residents can purchase their own clothes. Others require the assistance of staff. Residents do not have free access to the utility room. Four of the residents can access services in the community unaided. The local village is about a mile away but a bus service is available from the hospital gate.

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## SERVICE USER INVOLVEMENT

Information on treatment therapies is usually provided verbally to residents. There is a complaints policy in place. Some of the residents are not registered to vote. Apart from the care plan reviews, there are no formal mechanisms for seeking the views of residents or carers about the service, no community meetings and no advocate visits the residence. A self-medication programme is in place.

## RECORDS

The residents' medical and nursing files were tidy and legible. Residents cannot access their files or write in them. All entries were signed and dated but the titles of personnel were not always used. The files contained the resident's name on the front cover. They contained treatment plans and progress reports and a number of assessments. A signature bank was available for nursing staff. There were no entries from psychologists, occupational therapists or social workers. The medication sheets were in good order.

## ENVIRONMENT

The residence was clean and had been painted recently. Though it is located in a large institutional building, parts of the residence had a homely, comfortable feel to them and residents expressed satisfaction in this regard. The bedroom areas were formerly part of a hospital ward. While efforts have been made to create smaller, more intimate bedroom areas, the seven double rooms are not self-contained and are only separated from other bedroom areas by head-high partitions. There are gender specific toilets and bathrooms. There is a large sitting room with radio and TV. The location of the residence within a large hospital building and the use of the residence and building for other purposes militates against the stated aim of the residence to prepare residents for community living and the safeguarding of their privacy.

## ELLERSLIE HOUSE, BRAY

*Date of inspection:* 28th September 2005

*Number of beds:* 15 integrated

## DESCRIPTION

Ellersie House is a 15-bed residence with 24-hour nursing staff supervision. There is one respite bed. On the day of inspection there were ten male and five female residents. The residence is situated close to town and was opened as a high support residence in 1994.

## REFERRAL

The main source of referral is the hospital in Newcastle, GPs and outpatient clinics. There are three consultant psychiatrists who have access to the residence. The individual is referred to the day centre as part of the referral process. The referral is discussed at the multidisciplinary team meeting and the resident is given a trial period in the residence if appropriate.

## PROCESS OF ADMISSION

There is an admission policy in existence and staff are aware of this. The only exclusion criterion is a recent history of aggression. The reason for admission is mainly for rehabilitation purposes, but also for respite care. On admission, a full assessment is carried out and subsequent reviews occur either within the day centre or at an outpatient clinic every Tuesday. If there is a crisis the resident is escorted to the hospital in Newcastle. All residents are registered with a local GP. The staff interact with the residents on a regular basis to inform them of the admission process and also the treatment plan. There is also a community nurse involved and as much family support as possible. The initial treatment plan is documented in the nursing card index. There is a key worker system and regular staff are allocated to specific residents.

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### CARE PLAN

Care plans are nurse led and originated in the hospital but were modified by the residence staff. The care plans and residents needs are identified following a thorough assessment to identify the needs that leads to a care plan where goals and objectives are identified. Care plans are reviewed every two to three months. When the resident is deemed ready to leave the residence, a gradual and planned process is put into place.

### REHABILITATION TEAM

There is access to clinical psychology through the multidisciplinary team at the day centre. There is also occupational therapy at the day centre and access to a social worker.

### INVOLVEMENT IN REHABILITATION PROGRAMMES

The residents all attend the local day centre and are involved in programmes there. It is the philosophy of the residence that all the programmes are to assist the resident to move to a lower level of support.

### CLINICAL RISK MANAGEMENT

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

### UNIT MANAGEMENT

There are no temporary or long-term transfers. The residence is not used for any other purposes. The nursing staff within the residence are all qualified. During the day there is one staff nurse and a CNM2 and at night there is one staff nurse. The residence is self-staffing and there are two household staff on duty. The ethos of the residence is to provide a home, meet the needs of the residents and to provide as much independence as possible. There is a formal process of induction for residents and staff and there are appropriate policies and procedures present. Over the last two years, three residents have

moved to a low support residence and two have moved on to the community. Maintenance within the residence is provided by the maintenance department in Newcastle Hospital.

### HOUSE RULES

There are some rules in evidence which are instigated by the staff. They are reviewed every two to three months. Visiting times are flexible but people are asked to avoid the day centre session times. Residents are allowed to leave unsupervised and inform staff what time they will return. Meals are prepared on site by the care staff. Residents are involved in menu planning and shopping and have access to the kitchen to make drinks and snacks. Residents are not required to go to bed at set times but they are asked to be up for breakfast during the week. The residents manage their own finances wherever possible. There is a policy on financial management of residents' money and they have independent access to the money as required. Some of the elderly residents have their money collected for them and are allocated money as and when needed. Residents are currently paying rent at the previous rate and are awaiting a further directive from the HSE. Residents buy their own clothes in the local shops and are encouraged to carry out their own laundry. Residents access services in the community unaided and use all the local amenities and, it is reported, enjoy trips to the local area. Local facilities are within walking distance to the nearest public transport.

### SERVICE USER INVOLVEMENT

There is information available on treatment and therapies and residents' rights. Residents are eligible to vote and are encouraged to do so. There is a complaints policy and complaints are followed up appropriately. There are regular meetings seeking residents' opinions and also family members.

### RECORDS

The medical notes were stored at the day centre and so were not reviewed on this inspection. The nursing

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notes were of good standard and contained relevant and up-to-date care plans and a comprehensive assessment of the residents' needs. There are currently two residents on a daily self-medicating programme. All the drug card indexes are signed, dated and legible.

### ENVIRONMENT

There is regular, ongoing maintenance in place provided by the HSE. The décor of the residence was excellent and hygiene was also of high standard. The furniture within the premises was comfortable and appropriate. The residence consisted of a kitchen, two lounges, a sun room, utility room, shared bedrooms with divisions, an appropriate number of toilets and bathrooms and an office.

### STAFF TRAINING

It was reported that staff are encouraged and supported to undertake training courses.

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## RECOMMENDATIONS

### AREA 2

#### ELM MOUNT (ST. VINCENT'S HOSPITAL)

1. Each patient should have an individualised care plan that contains a social, psychological, occupational, nursing and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated by the patient's key worker. The system should be consistent across both floors.
2. All policies should be consistent across both floors.
3. Staff should rotate between the two floors to promote a consistent approach to patient care.
4. Overriding locks must be fitted to the toilet and bathroom doors.

#### LE BRUN HOUSE & WHITEHORN HOUSE, VERGEMOUNT HOSPITAL AND COISCÉIM UNIT

1. Each patient should have an individualised care plan that contains a social, psychological, occupational, nursing and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated

by the patient's key worker.

2. The unit should be self-staffing to ensure continuity of care.
3. All written interventions and prescriptions must be dated, have a legible signature with the name and designation of the clinician clearly printed.
4. There should be a structure in place for obtaining residents' and carers' views and feedback about the service.
5. There should be an increase in staff to provide therapeutic activities for the patients.
6. Essential maintenance work should be carried out as a matter of urgency and a maintenance programme put in place.

#### MOREHAMPTON LODGE AND SWANLEA COMMUNITY RESIDENCES

1. A multidisciplinary rehabilitation team should be introduced within the service.
2. Each resident should be assessed for their future accommodation needs and appropriate resources provided.
3. The units should be self-staffing to ensure continuity of care.
4. All written interventions and prescriptions must be dated, have a legible signature with the name and designation of the clinician clearly printed.
5. Essential maintenance work should be carried out as a matter of urgency and a maintenance programme put in place.

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## AREA 10

## NEWCASTLE HOSPITAL

## OVERALL RECOMMENDATIONS

1. Each patient should have an individualised care plan that contains a social, psychological, occupational, nursing and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated by the patient's key worker.
2. The unit should be self-staffing to ensure continuity of care.
3. All written interventions and prescriptions must be dated, have a legible signature with the name and designation of the clinician clearly printed.

## GLENCREE

1. All decisions to admit a patient should be discussed with a consultant psychiatrist.
2. The policy on nursing people in their night attire should be reviewed and also the use of refractory clothing.
3. Appropriate signage should be displayed advertising the use of CCTV.
4. Priority should be given to have the unit redecorated.
5. All patients should have access to an independent advocacy service.

## AVONMORE

1. There should be a structure in place for obtaining patients' and carers' views and feedback about the service.

## COMMUNITY RESIDENCES

## OVERALL RECOMMENDATIONS

1. A multidisciplinary rehabilitation team should be introduced within the service.
2. Each resident should be assessed for their future accommodation needs and appropriate resources provided.
3. Each resident should have an individualised care plan that contains a social, psychological, occupational, nursing and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the resident and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the resident has been involved in developing his or her care plan, and the resident must have a copy of the care plan. The care plan must be coordinated by the resident's key worker.

## FITZWILLIAM HOUSE

1. Consideration should be given to the practice of residents having to be out of the hostel during the day.
2. The unit should be self-staffing to ensure continuity of care.
3. All residents must have access to individual bank accounts.
4. There should be a structure in place for obtaining residents' and carers' views and feedback about the service.

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## CLUAIN MUIRE SERVICE

### OROPESA HOUSE

1. A multidisciplinary rehabilitation team should be introduced within the service.
2. Each resident should be assessed for their future accommodation needs and appropriate resources provided.
3. Each resident should have an individualised care plan that contains a social, psychological, occupational, nursing and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the resident and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the resident has been involved in developing his or her care plan, and the resident must have a copy of the care plan. The care plan must be coordinated by the resident's key worker.
4. All drug prescription cards must have discontinuation of medicines signed.
5. Priority should be given to have the hostel redecorated.

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**CENTRAL MENTAL HOSPITAL****UNIT A (FEMALE ADMISSION UNIT)***Date of inspection: 12th December 2005**Number of beds: 7***DESCRIPTION**

Unit A is a locked, ground floor unit for women. As it is the only female unit in the hospital, it provides a mix of acute care, continuing care and rehabilitative care.

**REFERRAL**

Unit A takes referrals in accordance with the service admission policy from Irish prisons, courts and local psychiatric services.

**PROCESS OF ADMISSION**

All female admissions are discussed at the Monday morning referrals and transfer meeting. Most admissions to the unit are planned but there are occasional urgent admissions. Prior to admission, a team community forensic nurse and consultant psychiatrist assesses a patient and a written pre-admission assessment is provided. This includes a risk assessment and preliminary assessment of treatment and care needs. Patients under the age of 16 years are not admitted. Some patients with intellectual disability are admitted. Following admission, the duty NCHD carries out a full psychiatric and physical examination. A nurse then carries out an assessment and formulates a care plan in conjunction with the patient. Newly admitted patients are sometimes nursed in their night clothes and observed every 15 minutes. There is no clear system of key working.

**CARE PLAN**

Each patient has an individual typed Treatment and Care Plan (TCP), which is filed in the medical notes and reviewed regularly. The multidisciplinary team reviews patients weekly. Each patient has a case

conference when this is required. The patient, family, primary service providers are all invited to attend and unit policy allows for a legal representative or an advocate to be invited if the patient wishes. The case conference notes are typed and filed in the medical notes. Each patient receives an individual copy of her TCP plan. There is also a formal discharge planning process in place.

**NURSING PROCESS**

The nursing care plan is based on the Roper Logan Tierney model and it was reported to be appropriate to the patients' needs. There are plans to develop a team nursing approach to care. A risk assessment is included in the TCP. There are three levels of observation on this unit – general, 15-minute and one-to-one. Staff wear identification badges.

**ACCESS TO THERAPY**

Five multidisciplinary teams admit patients to this ward. There is access through each team to occupational therapy, social work and clinical psychology. The consultant psychiatrist reviews the patients on a weekly basis. Medical and surgical consultations are provided by St. Vincent's Hospital, Elm Park and the results of X-rays and tests can be accessed quickly.

**ACCESS TO THERAPEUTIC PROGRAMMES**

According to staff, each patient has a needs-based individual therapeutic programme. This may include individual therapeutic input from a clinical psychologist or occupational therapist. Some of the patients attend a centre in an old hospital building that is called "the OT", staffed by a vocational officer but with no occupational therapy input. Activities in this centre include art work and contract work for which patients receive a small payment. It would seem to be difficult to organise a therapeutic group activity programme on the unit given the mix of newly admitted, acutely unwell patients and patients who are long stay on the unit.

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### ECT

No ECT is provided on the hospital campus.

### SECLUSION

There are two seclusion rooms on the unit. The seclusion register was in order. There is a seclusion policy in place.

### CLINICAL RISK MANAGEMENT

The hospital policies were updated in August 2005 and address clinical, operational, security, and health and safety issues. CCTV is not used on this unit. There is no form of mechanical restraint in use. Handcuffs are used for the external transfer of patients. There is a written policy in place regarding their use. Staff are offered regular in-service training on control and restraint, including de-escalation and breakaway techniques, and cardio-pulmonary resuscitation. There is an individual clinical risk assessment in each patient file. There is a system in place for the reporting and auditing of serious incidents.

### UNIT MANAGEMENT

As this is the only female unit, there are no transfers to other units within the hospital. Activities available on the unit include TV, newspapers, music, books and games. No patient is allowed off the unit unescorted. There is a minimum staff of five on duty during the day and two staff on duty at night. These numbers can be increased when necessary. Staff are centrally rostered. There are no household staff dedicated to this unit. Ward-based staff operate a system of two days on and two days off. There are male and female staff. There is a formal process of induction for staff. There is no ward clerk. Nurses from within the hospital provide phlebotomy services. A waiting list is in operation. There were no patients awaiting appropriate discharge placement. The set visiting times are between 1350h and 1540h and visits take place in the dining room on the unit with the exception of child visits which take place in the Seomra (separate cabin) on the hospital grounds. Meal times are 0830h, 1200h and 1700h. Drinks and

snacks are provided at other times during the day. Patients can place orders for items from the shop on Mondays and Tuesdays.

### SERVICE USER INVOLVEMENT

There is a patient information booklet. Leaflets were available on treatment and therapies and a local complaints policy is posted on the ward. Staff reported that community meetings were sometimes held on the unit. The Irish Advocacy Network will be introducing a service to the hospital next year. GROW meetings are held on campus, as is a carers' group.

### RECORDS

Each patient has an individual, typed Treatment and Care Plan (TCP) filed in the medical notes. The case conference notes are typed and filed in the medical notes. Each patient receives an individual copy of her TCP plan. The medical charts reviewed on the day of inspection demonstrated clear evidence of active and regular multidisciplinary team reviews. There was evidence of recordings by occupational therapy and social work staff. In the medical notes, there was no patient identifier on each page, professional titles were not consistently written in accordance with the hospital policy and there was no signature bank. A nursing signature bank was available. The nursing notes reviewed were tidy and easy to manage. The professional titles were not recorded. The card index system was in order.

### ENVIRONMENT

Unit A is located on the ground floor. There were seven bedrooms. There were waist-high walled partitions in the bedrooms around the toilet area. There was a sink in each room. The windows were sealed. There was no ventilation system. Clothes were stored on open shelves. There was one room with no in-room sanitation. It was known locally as the "strip room". The use of this room was not recorded as seclusion in the seclusion register. The Inspectorate was informed since the inspection that this room has been decommissioned. There were two seclusion rooms. The rooms were narrow and long.

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They had sealed windows. There were mattresses, refractory clothing and blankets in place. There were observation panels. There was no CCTV in use. There was no padding on the walls. There was no ventilation. The communal areas included a small kitchen, dining room and day room. The day room was divided by a partition. The dining room also functioned as an interview space and visitors' room. There were two external courtyard areas. All smoking was external. There was one office space. There was one utility room and one bathroom. There was one bath and one shower for seven patients. There were two store areas. All bedrooms were locked during the day except for the rooms of some long-term patients. Contract cleaners provided cleaning on an ad hoc basis. The cleaners did not clean the shower areas. There was a weekly work roster for patients to clean the ward.

## UNIT B (MALE ADMISSION UNIT)

*Date of inspection: 12th December 2005*

*Number of beds: 15 beds (10 operational)*

## DESCRIPTION

The Admission Unit B replaced Unit 1. It is a single-storey locked high secure unit that has recently been extensively refurbished. When ward staff numbers are increased, the remaining five beds will be brought into operation, increasing the number of beds to 15. On the day of inspection there were ten patients on the unit.

## REFERRAL

The Admission Unit takes admissions in accordance with the service admission policy from Irish prisons, courts, local psychiatric services and any unit in the hospital.

## PROCESS OF ADMISSION

All male admissions to the hospital are through the Admission Unit and through the Monday morning admissions and transfer meeting. Admissions are normally planned but urgent admissions occur on

occasion. A community forensic nurse and consultant psychiatrist assess the patient prior to admission. Patients under the age of 16 years are not admitted. Some patients with co-morbid mental illness and intellectual disability are admitted. Following admission, the duty NCHD carries out a full psychiatric and physical examination. A nurse completes an assessment and commences care plan. The patient's GP is not routinely contacted or informed regarding the admission. However, it was reported that GPs visiting prisons are always informed regarding the patients whose certificates they initiate. The patient is involved in preparing the care plan document. Patients are managed in seclusion and refractory clothing (referred to as "rugs") for at least the first 24 hours. At the time of inspection there was no key worker system.

## CARE PLAN

Each patient has an individual, typed Treatment and Care Plan (TCP). It is filed in the medical notes and reviewed as required, according to clinical need. The multidisciplinary team reviews patients weekly. Each patient has a case conference when this is required. The patient, family and primary service provider are all invited to attend. The case conference notes are typed and filed in the medical notes. Each patient receives an individual copy of his TCP.

## NURSING PROCESS

There are plans to develop a team nursing approach to care. The nursing care plan is based on the Roper Logan Tierney model. It is reported not to be particularly useful with this patient group. It contains a section on security issues but not on risk assessment or management. Risk is addressed in the TCP. There is a hospital observation policy. The unit operational policy specifies details of the observation and supervision applied to patients. There are three recognised levels of observation on this unit. Staff wear identification badges.

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**ACCESS TO THERAPY**

All five consultant psychiatrist-led multidisciplinary teams admit to this ward. There is access through each team to occupational therapy, social work and clinical psychology. The NCHD and medical staff review the patients as required. Medical and surgical consultations are to St. Vincent's Hospital, Elm Park. There are nursing and care officers on the ward daily. Patients have access to VEC teachers and other instructors in the workshop areas.

**ACCESS TO THERAPEUTIC PROGRAMMES**

A Wellness Programme is provided on the unit. There are a number of programmes based on the grounds of the hospital. Patients access these depending on leave – industrial therapy (5/7 days), garden project (7/7 days), Wildwood woodwork project (3/7 days), VEC classes (3/7 days), and drama (1/7 days). A GROW support group facilitates one meeting per week.

**ECT**

No patient was in receipt of ECT. ECT is provided off site.

**SECLUSION**

The seclusion register was in order. There is a seclusion policy in place. Refractory clothing is used.

**CLINICAL RISK MANAGEMENT**

There are hospital policies in place dated August 2005. The policies are divided into clinical, operational, security and health and safety. CCTV is in use on the ward, at the entrance points, exercise area and car park. It is not used on the seclusion room, bedrooms or day room. There is no policy in place. The CCTV is on a 90-day recording cycle. There are no signs indicating CCTV is in use. There is no form of mechanical restraint in use. Handcuffs are used for the transfer of patients externally. There is a written policy in place regarding their use. Staff are offered regular in-service training on manual handling techniques. A record is held centrally. There is a

detailed typed clinical risk assessment in each patient file. There is a policy and flow chart on the reporting and recording of serious and untoward incidents.

**UNIT MANAGEMENT**

There are no temporary transfers to other units or sleeping out. Patients may be transferred to the Selective Adaptive Behaviour Unit (SABU) for specialist intervention or to Unit 2 as they improve. They may be discharged directly back to prison. Patients are not allowed off the ward unescorted. There are seven staff on duty during the day and three at night. When this complement increases, the remaining beds will be brought into operation. Ward-based staff operate a system of two days on and two days off with a ward manager for each of these teams. Ward-based staff are integrated male and female. There is a contract cleaning service that provides two staff each day from 0800h to 1800h. Staff reported that there had been a significant improvement since this service had been obtained. There is a recognised process of induction for staff. There is no ward clerk. Some of the nursing staff are trained in phlebotomy and there is a nurse phlebotomy service. Delays were reported in obtaining maintenance work. Visits take place on the unit in the dining area. Visiting times were from 1445h to 1545h Monday to Wednesday and Friday to Saturday. There were no visits on Thursdays and it was reported that this was due to an ongoing industrial relations issue. It has since been reported that booked evening visits have commenced on Thursdays. Child visits were in accordance with the child visiting policy. Meal times were 0915h, 1230h and 1730h to 1800h with regular snacks during the day.

**SERVICE USER INVOLVEMENT**

There is a patient information booklet and a local complaints policy is posted on the ward. Community meetings are planned. The Irish Advocacy Network will be introducing a service next year. Currently a number of voluntary groups and carers group are facilitated on campus. A number of patients were seen. The following issues were raised:

1. One patient was upset about the amount of seclusion he was receiving and requested a

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transfer to the SABU, which occurred later that day. His being locked into the exercise area on his own was not being recorded as seclusion, even though it clearly was. The seclusion policy needs to take this situation into account and the register amended accordingly

2. Other patients were concerned that they could not receive their treatment nearer to their homes and families
3. Patients were concerned about the lack of psychotherapy, particularly for helping them to cope with what they had done. They were upset about the verdict of "guilty but insane" feeling that instead it should be "not guilty but insane"
4. Some patients were concerned about forcible treatment with injections. They would like TVs in their own rooms and lockers to house the TVs
5. Two patients said that they had not received copies of the TCP
6. Some expressed a desire for a second independent opinion from outside the service.

## RECORDS

There were two records, a medical chart and nursing notes. The medical chart contained a typed detailed case history, a typed risk assessment form and a typed TCP. The notes were well laid out, tidy and showed evidence of regular medical reviews. There was no space on the note sheets to record a patient identifier. The policy on documentation stated that all entries should sign with professional grade but there was no evidence of this in the charts reviewed, although it was clear from the charts of multidisciplinary team reviews. There were no entries from other disciplines evident in the charts reviewed. The nursing notes were in order. They contained a summary sheet and photograph of the patient. They were signed and dated. There was no signature bank available for any discipline. The card index system was in order. There was no separate space for "as required" medications/depot injections.

## ENVIRONMENT

Unit B had been extensively refurbished and had been open less than 12 weeks at the time of inspection. There were three corridors on the unit. The nursing office was beside the main entrance. This was a large room with adequate space and opposite it was an interview room. There was a day room, leading out to a large secure exercise yard. There was also a small secure exercise yard, and this was used for people in seclusion. Off the day room was a small area with four bedrooms and bathroom facilities. This bedroom area had not yet been used. Another corridor contained the kitchen and the dining area, which doubled as the visiting room. The clinic room adjoined the dining room and had a hatch on the door from which medication was dispensed. It had a full range of emergency equipment available. There was a staff room, examination room, offices and a separate entrance to the unit for visitors. This door had a camera and communications facility. The third corridor contained 11 bedrooms, the two seclusion rooms, a "step-down" room in the vicinity of the seclusion rooms and shower and toilet facilities. All the bedrooms had combined stainless steel sink and toilet units, with drinking water available. It was planned to erect shelves for storage and for TVs in the bedrooms. The air quality and temperature in the unit was computer controlled. The "step-down" room was not being used at the time of inspection because of safety issues concerning the layout of the room and the design of the furniture. The seclusion rooms were very clinical. They were brightly painted and well lit. The curtains were secured to the windows with velcro tabs. An en-suite toilet was shared by the two seclusion rooms and the doors could be electronically operated from outside by staff. The doors had observation panels but no communication facility. The surfaces of the walls and floors were hard. Some of the plaster had been removed from the surrounds of the doors. Unit B had a dedicated household staff member and the unit was clean and hygienic on the day of inspection.

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**UNIT 2 (MALE MEDIUM SECURE UNIT)**

*Date of inspection:* 12th December 2005

*Number of beds:* 13

**DESCRIPTION**

Unit 2 is a medium secure male ward. It is located on the first floor and is only accessible by stairs. It has 13 beds and was at full capacity on the day of the inspection.

**REFERRAL**

There are no direct admissions. Patients are transferred following discussion at the weekly hospital referrals and transfers meeting and multidisciplinary team meeting. The clinical notes follow the patient.

**PROCESS OF ADMISSION**

There is a hospital admission policy. All patients are nursed in day clothes. It was reported that there is one level of observation on this unit. A key nurse system is being introduced.

**CARE PLAN**

Each patient has an individual, typed Treatment and Care Plan (TCP). It is filed in the medical notes and reviewed as appropriate to clinical need. The multidisciplinary team reviews patients weekly. Each patient has a case conference when this is required. The patient, family and primary service provider are all invited to attend. The case is typed and filed in the medical notes. Each patient receives an individual copy of his TCP.

**NURSING PROCESS**

The nursing model currently in use is under review. It is planned to introduce the Camberwell Assessment of Need – Forensic Version (CANFOR) and training was to begin in January 2006. Each patient has a detailed risk assessment completed. This is typed and

filed in the chart. There is a hospital policy on observation. It was reported that there is one level of observation on this unit. Staff wear identity badges.

**ACCESS TO THERAPY**

All five consultant psychiatrist-led teams admit to this ward. There is access to occupational therapy, social work and clinical psychology. The NCHD and medical staff review the patients as required. Medical and surgical consultations are provided in St. Vincent's Hospital, Elm Park. There are nursing staff and care officers on the ward daily. Patients have access to VEC teachers and other instructors in the workshop areas.

**ACCESS TO THERAPEUTIC PROGRAMMES**

There are a number of programmes based on the grounds of the hospital. Patient access these depending on leave – industrial therapy (5/7 days), garden project (7/7 days), Wildwood woodwork project (3/7 days), VEC classes (3/7 days) and drama (1/7 days). A GROW support group facilitates one meeting per week. There is one ward-based current affairs group.

**ECT**

No patient was in receipt of ECT. ECT is provided off site.

**SECLUSION**

Seclusion is not in use on the ward. The rooms are locked nightly from 2045h. This is not recorded as seclusion in accordance with the Mental Treatment Act 1945.

**CLINICAL RISK MANAGEMENT**

The hospital policies were updated in August 2005 and address clinical, operational, security and health and safety issues. CCTV is not used on this unit. There is no form of mechanical restraint in use.

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Handcuffs are used for the external transfer of patients. There is a written policy in place regarding their use. Staff are offered regular in-service training on control and restraint, including de-escalation and breakaway techniques and cardiopulmonary resuscitation. There is an individual clinical risk assessment in each patient file. There is a system in place for the reporting and auditing of serious incidents.

### UNIT MANAGEMENT

Nursing and care officers staff the ward. On the day of inspection, there was one CNM2, four staff nurses and two care officers. Two staff nurses and one care officer are rostered on night duty. All staff are rostered from a central base. There is limited access to contract cleaners for the ward daily. Their tasks are not defined. Maintenance is provided from the hospital-based maintenance department. It was reported that response times are variable.

Visiting times are fixed or by request. Visitors are not allowed on the ward. Visitors are accommodated in a room downstairs or in the dining room. Child visits took place in the Seomra in accordance with the child visiting policy. Patients had access to the gymnasium and swimming pool and to football in the "ball alley" area behind Unit B, unless their risk assessment indicated that this should not occur. Recreation officers managed the gymnasium and swimming pool.

Meal times are set and served in the dining room off the ward downstairs. Tea and biscuits are served at 1900h. The bedrooms are locked at night. There is no call system. Patients must attract staff attention to use the toilet facilities at night. On the day of inspection, it was reported that there were two patients awaiting transfer to the ward. All new staff receive a hospital and ward induction. The wearing of a uniform by staff is optional.

### SERVICE USER INVOLVEMENT

There is a patient information booklet and a local complaints policy is posted on the ward. Community meetings are planned. The Irish Advocacy Network is introducing a service next year. A number of

voluntary groups and a carers' group are facilitated on campus.

### RECORDS

The medical and nursing files were generally tidy and legible but some of the medical files had many loose pages at the back. All entries were signed and dated. Many medical and nursing entries did not contain the titles of personnel. On some entry sheets the name and ID numbers of patients was omitted. The medical files contained TCP forms at the front. They also contained treatment plans and progress notes from doctors, social workers and occupational therapists. There were frequent consultant psychiatrist and NCHD reviews. Some of the files contained Assessment of Risk forms. A stamp in the notes was used to identify decisions taken at team meetings. A signature bank was available for nursing staff. The medication sheets were in good order but the discontinuation of medication was not always signed and dated.

### ENVIRONMENT

Unit 2 is located on the first floor. Access was via the stairwell and air-lock entrance nearest the nursing office. Access to the exercise yard and to the ground-floor dining room was through the second stairwell. Maintenance was not satisfactory. Ventilation was poor, with little fresh air. The unit was in need of refurbishment. There was a long corridor with day rooms at one end and sleeping rooms opening onto it. The corridor was used as a seating area and was sometimes kept locked. There were information boards. There were telephones on the corridor, which were locked and opened as required.

The main meal was taken in the ground floor dining room. Snacks were taken in the corridor or day room. There were plans to install a lift for goods and food and to provide all meals in the unit dining room. There was a kitchen on the unit, along with a utility room with washing machine and dryer. There were 13 bedrooms and one seclusion room, which was no longer in use. These did not have en-suite facilities. All bedrooms were small and cramped and poorly decorated. They had TVs and were locked at night. There was a toilet at the end of the corridor, which

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was opened at night.

There was a day room, which had a TV, radio and pool table. Newspapers were delivered daily. There were always two staff members in the day room if patients were there. The complaints procedure was displayed. The windows were old and wedged open by newspapers. The toilets were located off the day room and were kept locked. There was a room with a bath and two shower cubicles which required modernisation. A separate room had ten wash-hand basins. Soap dispensers were being installed. Shaving materials were kept in a locker. There were two toilet cubicles and a sluice room.

Beside the day room there was a room with a full size snooker table, which was opened when staff were able to be present. There was a bright, pleasant, small sitting/dining area with comfortable seating, which was kept locked and was used sometimes as a quiet area. A staff member had to be present. There was a nurses' office, which was centrally located and doubled up as an interview room. All staff carried alarms. There was no IT support. Apart from a toilet, there were no staff facilities. The clinic room had an examination couch and routine physical examinations were performed here. It contained an emergency box and the medication. There was a large interview room, which was also used for multidisciplinary team meetings and daily activities. There was a secure exercise area shared with Unit 3.

### UNIT 3 (MALE MEDIUM SECURE UNIT)

*Date of inspection:* 13th December 2005

*Number of beds:* 16

#### DESCRIPTION

Unit 3 is a locked 16-bed medium secure unit located on the second floor.

#### REFERRAL

This unit typically takes patients transferred from Unit 2 or on transfer from other less secure units. The unit aims to deliver a service to patients who have progressed in their rehabilitation while in Unit 2 but

are not yet ready for discharge. The risk assessments of these patients now indicate that they can safely use escorted leave within the grounds of the hospital and outside of the hospital (though this leave may not have yet been granted by the Department of Justice). All referrals are discussed at the Monday morning referrals and transfer meeting for the hospital.

#### PROCESS OF ADMISSION

There is a hospital admission policy. There are no direct admissions to this unit. The last transfer had occurred approximately one month prior to inspection when another patient was transferred to Unit 7.

#### CARE PLAN

A treatment plan should in all cases have been prepared prior to transfer. This occurs at a case conference attended by the referring multidisciplinary team, the admitting multidisciplinary team from the CMH, the person in charge of the unit, the patient and/or relatives or carers, advocates and any outside agencies involved. The Treatment and Care Plan (TCP1) and Risk Assessment (TCP2) are kept in the clinical notes and used by all stakeholders. There are six-monthly case conferences at which the TCP is reviewed. There is documented participation by the patient in his care plan.

#### NURSING PROCESS

The nursing process is based on the Roper Logan and Tierney model. An individual care plan is maintained by ward staff, who make a daily record for all patients. There are weekly multidisciplinary team meetings where the TCPs are reviewed. Team nursing has been introduced. There is a hospital observation policy. Patients here are deemed to be on level 1 observation, which is general observation within a locked ward.

#### ACCESS TO THERAPY

Access to psychology, occupational therapy and social work is through the multidisciplinary teams. The

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consultant psychiatrist and registrar attend regularly. Medical and surgical consultations are provided at St. Vincent's Hospital, Elm Park. Advocacy services were being made available at the time of inspection.

#### ACCESS TO THERAPEUTIC PROGRAMMES

The psychologist conducts programmes for dealing with offending behaviour. A Wellness Recovery Action Programme and current affairs group is conducted on the unit by the occupational therapist. GROW and AA meetings are available. Available on site are VEC programmes including literacy, art, music and education up to Leaving Certificate level, a wood turning workshop with Wildwood, industrial therapy, drama with Calypso Theatre Company, and a garden project. Patients have access to the gymnasium and swimming pool and to football in the "ball alley" area behind Unit B unless their risk assessment indicates that this should not occur. Some patients are involved in community rehabilitation activities, such as the Usher's Island Day Programme, Thomas Court, community VEC or third level education.

#### ECT

ECT is not administered in this service. Patients go off site if it is prescribed.

#### SECLUSION

Seclusion is not used on this unit although all patients are locked into their rooms at night and this is not recorded as seclusion.

#### CLINICAL RISK MANAGEMENT

Each patient has a detailed risk assessment completed. This is typed and filed in the chart.

It is planned to introduce the Camberwell Assessment of Need – Forensic Version (CANFOR) and training was to begin in January 2006. Staff are offered training yearly. This is recorded centrally. Restraint using handcuffs is in use during escorts. It was reported that use of restraints in this way is

logged and infrequently used. There is a policy in place. No other form of mechanical restraint is in use.

#### UNIT MANAGEMENT

Patients may be transferred back to the male admission unit, Unit B, or Unit 2 in the event of an acute deterioration or may be transferred to the Unit 4, the Selective Adaptive Behaviour Unit (SABU), subject to a referrals process in accordance with the operational criteria for that unit. The unit is always locked in accordance with the observation policy. One patient at the time of inspection went out on unaccompanied parole twice a week as part of a planned move. There is no CCTV on the unit. Some patients from Unit 7 come to this unit in the evenings for card games. The ward is staffed by nursing and care officers. There are six staff on duty by day and two staff on duty by night. The staff-to-patient ratio is lower than that for Unit 2.

At present, patients still slop out at night. When the number of night time staff increases to three, there are plans to stop this practice and replace it with a system of bell-calls so that patients can be escorted to the bathroom at night.

All staff are rostered from a central base. Ward-based staff currently operate a system of two days on and two days off with a ward manager for each of these teams. Ward-based staff are integrated male and female. There is limited access to contract cleaners for the ward daily and they attend to the bathrooms. Patients do their own bathrooms and common areas in accordance with a rota system. Problems were reported with obtaining maintenance, which is provided from the hospital.

Visiting times are fixed or by request. Visitors are accommodated in a room downstairs or in the dining room. Meal times are set and served in the dining room off the ward downstairs. Tea and biscuits are provided at 1900h. Patients are allowed supervised access to the kitchen.

The bedrooms are locked at night. There is no call system. Patients must attract staff attention to use the toilet facilities at night.

On the day of inspection, it was reported that there were two patients awaiting transfer to the ward. All

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new staff receive a hospital and ward induction. The wearing of a uniform by staff is optional. There was no financial policy in place for the management of patient finances. It was reported that this policy is in draft form and awaiting a legal opinion in respect of patients' opening individual bank accounts. The standard hospital policies were available on the ward for inspection.

### SERVICE USER INVOLVEMENT

There is a patient information booklet and a local complaints policy is posted on the ward. Community meetings are planned. The Irish Advocacy Network will be introducing a service next year. Currently a number of voluntary groups and carers group are facilitated on campus. During the inspection, one patient requested information on his rights. This information is not available in the information booklet. Another patient complained about being given cold teas in winter and about being locked in his room for 12 hours at night with no access to food.

### RECORDS

The medical charts reviewed on the day of inspection demonstrated clear evidence of active and regular multidisciplinary team reviews. There was evidence of recordings by occupational therapy and social worker staff. One chart reviewed also contained a recovery action plan. Each patient had a TCP, risk assessment and case conference typed notes in place. There was no patient identifier on each page, professional title was not consistently written in accordance with the hospital policy and there was no signature bank for all staff. A nursing signature bank was available. The nursing notes reviewed were tidy and easy to manage. The card index system was in order.

### ENVIRONMENT

Unit 3 was a locked unit on the second floor of the hospital. Access to the unit was via the stairwell opposite the nursing office. There were 16 bedrooms on the unit but 13 of the bedrooms were quite small. Each contained a bed, storage facilities and TV. There

were no en-suite facilities. At one end of the unit there were three larger bedrooms. There was a large nursing office and a staff toilet. There was a kitchenette, a dining room, a large day room, a room that contained a pool table, and two TV lounges for patients. There was a clinic room and an interview room, which was also used for team meetings. There were a number of storerooms, one shower, one bathroom and three toilets.

There were notice boards, which detailed the complaints policy and gave information on a range of activities within the hospital. At the time of inspection a lift was being installed so that meals could be brought to the ward. Patients went to the ground floor dining room for their main meal. This room was also used as a visiting area. Patients used the exercise yard on the ground floor. There were two shelters in this yard and, since the last inspection; three stainless steel toilets had been installed. The hand basins were in an uncovered area in the yard and no towels or drying facilities were available. The unit was clean but the decor was drab. Some of the bedroom windows could be opened but the air quality was controlled by a central system.

### UNIT 4 (SELECTIVE ADAPTIVE BEHAVIOUR UNIT – SABU)

*Date of inspection:* 13th December 2005

*Number of beds:* 6

### DESCRIPTION

The Selective Adaptive Behaviour Unit (SABU) is a six-bed male unit opened in the month prior to inspection. At the time of inspection there were four patients there. Its stated aims are to provide a service for patients who have required prolonged periods of seclusion or close observation due to treatment-resistant mental disorders and who present complex needs, usually including both behavioural and pharmacological treatments where changes in the course of treatment can lead to problems of increased risk to the patient and others. The establishment of this unit is a welcome development and it is anticipated that it will result in a marked reduction in the use of seclusion, and will extend the range of therapeutic activities available to patients.

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#### REFERRAL

The operational policy for the SABU states that it will take transfers from any unit in the hospital as per its policy. It will not admit patients directly from outside the hospital.

#### PROCESS OF ADMISSION

There are no direct admissions. Patients transferred to the SABU remain the responsibility of the original admitting team but while in the unit their day-to-day care is managed by the multidisciplinary team leading the SABU.

#### CARE PLAN

A treatment plan should in all cases have been prepared prior to transfer. This occurs at a case conference attended by the referring multidisciplinary team, the admitting multidisciplinary team from the CMH, the person in charge of the unit, the patient and/or relatives or carers, advocates and any outside agencies involved. The Treatment and Care Plan (TCP1) and Risk Assessment (TCP2) are kept in the clinical notes and used by all stakeholders. There are three-monthly case conferences at which the TCP is reviewed. There is documented participation by the patient in his care plan. The staff in the SABU plan to transfer patients to other units but not necessarily the unit from which the patient was admitted. They will aim to identify the discharge route in the pre-admission case conference and treatment plan.

#### NURSING PROCESS

The nursing process is based on the Roper Logan and Tierney model. An individual care plan is maintained by ward staff, who make a daily record for all patients. There are weekly multidisciplinary team meetings where the TCPs are reviewed. Patients are observed in accordance with the hospital observation policy. The unit operational policy specifies details of the observation and supervision applied to patients. Because of the specialised nature of this unit, staff are receiving training in behaviour modification, which was to commence formally in February 2006. In the meantime, there was daily training on the unit

for all staff provided by the Nurse Education Department and consisting of 12 modules.

#### ACCESS TO THERAPY

While they are in the SABU, patients' day-to-day treatment and care are managed by the multidisciplinary team leading the SABU. Access to psychology, occupational therapy and social work is through this multidisciplinary team. The consultant psychiatrist and registrar attend daily. Provisionally there are two sessions of clinical psychology input and nine hours of psychology assistant time per week. There are plans to introduce a key worker system. Medical and surgical consultations are provided at St. Vincent's Hospital, Elm Park. Advocacy services were being made available at the time of inspection.

#### ACCESS TO THERAPEUTIC PROGRAMMES

There are plans to have activities on and off the unit. Access to programmes off the unit would first require assessment on the unit. A Functional Behavioural Assessment Protocol is being developed by the clinical psychologist for the service with a view to developing Behavioural Intervention Plans. As this is a new service the emphasis at the time of inspection was on detailed assessment and on avoidance of the use of seclusion.

#### ECT

ECT is not administered in this service. Patients go off site if it is prescribed.

#### SECLUSION

There is one seclusion room on the ward. There is one mattress in place and a window. There is no ventilation and staff can see into the room through a window. There is no CCTV in use. All patients in seclusion wear refractory clothing. There are no ensuite facilities. There is no soft finish on the walls. There is no call bell system in place for the patient to communicate with staff. The seclusion register was in order.

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**CLINICAL RISK MANAGEMENT**

The hospital policies were updated in August 2005 and address clinical, operational, security and health and safety issues. CCTV is not used on this unit. There is no form of mechanical restraint in use. Handcuffs are used for the external transfer of patients. There is a written policy in place regarding their use. Staff are offered regular in-service training on control and restraint, including de-escalation and breakaway techniques, and cardio-pulmonary resuscitation. There is an individual clinical risk assessment in each patient file. There is a system in place for the reporting and auditing of serious incidents.

**UNIT MANAGEMENT**

There are no temporary transfers to other units. Patients are transferred in accordance with their care plan once certain goals are achieved. It is a locked unit and bedrooms are kept locked. The practice of slopping out continues. The unit is not used for any other purposes. There are five staff on by day and two at night. Nursing management endeavour to ensure consistent staffing. Contract cleaners attend to the domestic work. There is no ward clerk. Nursing staff take blood samples when required. There is no waiting list. Mealtimes are at appropriate times and meals are brought to the unit.

**SERVICE USER INVOLVEMENT**

Some of the patients were interviewed. They preferred the new service to the units they had been transferred from.

**RECORDS**

The medical and nursing files were legible and tidy. Some of the continuation sheets contained neither the patient's name nor an ID number. All entries were signed and dated but the titles of personnel were rarely used. The medical files contained treatment plans and progress notes from medical and other personnel. The files, which were examined, contained TCPs. There was evidence of three-monthly multidisciplinary case conference reports and

Assessment of Risk forms. There was evidence of regular consultant psychiatrist and NCHD reviews. A signature bank was available for nursing staff. The medication sheets were generally in good order but some of the prescription sheets needed to be rewritten and discontinuation of medication was not always signed and dated.

**ENVIRONMENT**

This unit was opened in October 2005 to provide a safe therapeutic environment for six patients with challenging behaviour and management problems. The bedroom area included one seclusion room. The bedrooms were small and consisted of a bed area and a sealed window. The wardrobes were located on the corridor. There were no en-suite facilities and the doors were locked at night. Slopping out was still in practice. There was a dining room with three fixed tables. Each table had four attached seats. The day room was of adequate size and decor. There was access to an enclosed garden space. The garden had seating and grassed areas. Patients were escorted at all times into the garden. There was one office area. There was adequate space for staff. There was a kitchen area to prepare food on arrival from the main hospital kitchen. There were two toilets, a sluice area and one bathroom. The bathroom had a bath and a shower. The area was tiled and clean on the day of the inspection.

**UNIT 7 (MALE REHABILITATION UNIT)**

*Date of inspection:* 13th December 2005

*Number of beds:* 14

**DESCRIPTION**

Unit 7 is a male rehabilitation unit. The unit is open and all patients have leave arrangements. All five multidisciplinary teams admit to the unit. The age profile is from 24 to 63 years old.

**REFERRAL**

There are no direct admissions. Patients are transferred internally from Unit 3 or the hostel. All

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referrals are discussed at the weekly bed management meeting and the multidisciplinary team reviews.

#### PROCESS OF ADMISSION

All new referrals are progressed in their rehabilitation pathway and have been assessed to meet admission criteria for this unit. The clinical notes and risk assessment file follows the patient from the previous unit or hostel. The clinical teams review the patients. Patients are all dressed and have leave on the grounds and to the community. All patients are on general level of observation. There is no key nurse or key worker system in place. It was reported that the lack of a consistent staff is a contributory factor.

#### CARE PLAN

Each patient has a treatment care plan, risk assessment and ongoing reviews by the multidisciplinary team. A case conference is held every three months. The notes are typed and filed in the chart. There was no rota for patient reviews and it was difficult to establish if the standard was being achieved. The multidisciplinary team meet on or off the unit.

#### NURSING PROCESS

There is no defined model in use. The process is Activity of Daily Living (ADL) focussed. Each patient has a typed risk assessment completed. There is no key nurse system in place. All staff wear ID badges and all patients are on general level of observation.

#### ACCESS TO THERAPY

There are five multidisciplinary teams with admitting rights to the unit. The majority of teams have an occupational therapist, clinical psychologist and social worker member. There is regular access to a consultant psychiatrist, nursing staff and community nursing staff. All medical and surgical consultations are to St. Vincent's Hospital, Elm Park.

#### ACCESS TO THERAPEUTIC PROGRAMMES

This is an open rehabilitation ward. The patients have leave defined by the multidisciplinary team. A number of patients attend courses off site unaccompanied. Other patients attend Ushers Island Day Service on set days. They are driven to the centre. A number of other patients access the VEC course options, industrial therapy and recreational therapy on site. There is a weekly meeting to discuss progress of patients attending the onsite activities.

#### ECT

ECT is not provided on the hospital campus.

#### SECLUSION

Recorded seclusion is not in use. The majority of bedrooms are locked by night. Patients must call for assistance during the night to access toilet facilities. One patient has a call bell because of his ongoing physical health problems. Patients continue to slop out daily.

#### CLINICAL RISK MANAGEMENT

There are standard policies on risk and the management of risk across the hospital. An in-service programme is provided for staff on cardio-pulmonary resuscitation, prevention and management of violence and aggression (PMVA) and manual handling. Records of attendance are held centrally. Each patient has an individual risk assessment. Serious incidents are reported in accordance with the hospital policy. It was reported that serious incidents are rare on this unit.

#### UNIT MANAGEMENT

The unit is staffed daily by nursing and care officer grade staff. There are three staff on duty by day and two staff by night. It was reported that if staffing increased at night the bedroom doors could remain open. On the day of inspection, there were two people awaiting transfer. It is estimated that five to

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six patients could move to a 24-hour staffed residence in the community if it were available. The ward staff are rostered centrally. Maintenance is provided by the hospital maintenance department. The environment is of a poor standard. Mealtimes are set. Patients are encouraged to make small snacks and have access to the kitchen area. Visiting time is flexible and in accordance with hospital policy.

## SERVICE USER INVOLVEMENT

There is a hospital information booklet. There are informal community meetings. The Irish Advocacy Network will commence a service on the ward in January 2006. There is a monthly meeting between the patients and management team. There is also access to GROW meetings and a carers group. One patient, who was interviewed, had a number of complaints. He said that the term "parole" should be replaced by the term "leave". He complained about the rigidity of locking people into their rooms at 2045h. He was also concerned that the double doors on the bedrooms and the metal grills on the windows constituted a fire risk.

## RECORDS

The notes reviewed were tidy and easy to manage. There were typed case summaries, TCPs and risk assessment in place. There was evidence of regular contact from the multidisciplinary team. It was difficult to establish the dates for each review in the absence of a rota. There was no patient identifier space on the notepaper. The notes were signed but contained no printed name and no professional title as per the hospital policy. There was no signature bank except for nursing staff. The nursing and care officer notes are separate. The notes reviewed were in order. There was a signature bank on the card index folder. The medication sheets reviewed, in some instances, need to be rewritten, as they were difficult to read. There was no defined space to write up depot medication.

## ENVIRONMENT

Unit 7 is a ground floor unit that accommodates 14 patients. On the outside of the unit was a verandah. The main door to the unit led from the verandah into the day room, which doubled as a dining room. The unit comprised rooms on two corridors. On one corridor, which adjoined the former Unit 1, was the nursing office that was also used as an interview room and meeting room, and 11 bedrooms. The bedrooms were small and did not have en-suite facilities. They had double wooden doors and they had metal grills on the insides of the windows. The other corridor contained three bedrooms, a laundry room, bathroom and toilet facilities, a clinic room and a kitchenette. The unit also had an inner garden. The decor of the unit was drab. The bathroom and toilet facilities needed to be upgraded and the flooring needed to be replaced in the kitchenette and day room. The building is a flat-roofed structure and it was poorly insulated. There were a few leaks. The physical environment was not supportive of a rehabilitation ethos.

## HOSTEL

*Date of inspection:* 13th December 2005

*Number of beds:* 10

## DESCRIPTION

The Hostel is a two-storey domestic style house, originally built for the Resident Medical Superintendent but used as a residence for patients since 1996. It is an open unit, which, although intended as a stepping-stone to a community placement, has a number of long-stay residents.

## REFERRAL

The hostel takes transfers in accordance with the service admissions policy from Unit 7 and on rare occasions from Unit 3. All transfers to the hostel are discussed at the Monday morning referral, admission and transfer meeting for the service.

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#### PROCESS OF ADMISSION

Typically patients will have progressed in their rehabilitation while in Unit 7 but are not yet ready for discharge. In the past the Hostel was used for elderly and "settled" patients, many of whom had spent years in the main hospital units. Increasingly the Hostel takes younger patients who are in the process of active rehabilitation and spend much of the day engaged in activities elsewhere.

#### CARE PLAN

Each patient has an individual typed multidisciplinary Treatment and Care Plan (TCP). It is filed in the medical notes and reviewed as appropriate to clinical need. Each patient has a case conference when this is required. The patient, family and primary service provider are all invited to attend. The case conference notes are typed and filed in the medical notes. Each patient receives an individual copy of his TCP plan.

#### NURSING PROCESS

It was reported that the nursing care plan is based on the Roper Logan Tierney model. It was since reported that it is planned to introduce the Tidal Model. The TCP contains the risk assessment. As there is only one staff member on duty by day and by night there is no key worker system. All residents here are on general observation while in the unit. Their risk assessment has been revised so that they can safely use unescorted leave within the grounds of the hospital and typically will have some unescorted leave in the community.

#### ACCESS TO THERAPY

All five consultant psychiatrist-led multidisciplinary teams admit to the hostel. There is access to occupational therapy, social work and clinical psychology through each team. The NCHD and medical staff review the patients as required. Medical and surgical consultations are provided in St. Vincent's Hospital, Elm Park.

#### ACCESS TO THERAPEUTIC PROGRAMMES

All therapeutic programmes are provided outside of the Hostel, in accordance with the care plan and where staff resources permit. Residents have access to the Wellness Recovery Action Plan, GROW, AA, VEC including literacy, art, music and education up to Leaving Certificate level, industrial therapy, Wildwood wood turning, Calypso Theatre Company drama programmes, a garden project, and community rehabilitation activities that include the Usher's Island day programme, Thomas Court, FÁS and community VEC or third level education.

#### ECT

ECT is not provided on the hospital campus.

#### SECLUSION

There is no seclusion.

#### CLINICAL RISK MANAGEMENT

There are hospital policies in place dated August 2005. The policies are divided into clinical, operational, security and health and safety categories. There is a detailed typed clinical risk assessment in each patient file. There is a policy and flow chart on the reporting and recording of serious and untoward incidents.

#### UNIT MANAGEMENT

There were no temporary or long term transfers from this unit. There were no patients in the unit on the day of inspection. The staff member on duty carries a two-way radio at all times and responds to alarms in other areas of the hospital. Visits take place in the main dining or visiting hall unless otherwise agreed by the multidisciplinary team, in which case, visits may be accommodated in the Hostel with an agreed level of supervision. Child visits take place in the Seomra or where agreed and supervised in the grounds of the hospital in accordance with the child visiting policy.

## SERVICE USER INVOLVEMENT

There is a service information leaflet. The Advocacy Network had recently been introduced to the staff and patients. A service will commence in 2006.

## RECORDS

There were two records, a medical chart and nursing notes. The medical chart contained a typed detailed case history, typed risk assessment form and typed treatment care plan (TCP). There was no space on the note sheets to record a patient identifier. The nursing notes were in order. They contained a summary sheet and photograph of the patient. They were signed and dated. The card index system was in order.

## ENVIRONMENT

The Hostel is a stand-alone two-storey building on the main avenue of the hospital grounds. On the ground floor, there was a sitting room and living room, both with TVs, a kitchen, dining room, nursing office, two bedrooms and a toilet and shower. Upstairs there were eight bedrooms, a toilet, bathroom and shower. To the rear of the house was a small paved area, picnic tables and gazebo, which was used for smoking. The house had a homely atmosphere and was clean throughout. It was reported that the rooms in the hostel were painted by the patients, who also chose the colours. The bedrooms, which had observation panels in the doors, were locked and all residents had their own keys. Some of the bedrooms were quite small. Some parts of the house needed re-painting. A cupboard and several tiles needed to be replaced in the kitchen.

## CENTRAL MENTAL HOSPITAL

### OVERALL RECOMMENDATIONS

1. The practice of slopping out must cease.
2. A key worker system should be introduced.
3. The practice of locking patients in their rooms at night regardless of status should be reviewed.
4. There should be sufficient cleaning hours contracted for the hospital to satisfactorily address the needs of all areas.
5. There should be a rolling maintenance programme to address the environmental needs of the entire service.
6. All written interventions must be dated, have a legible signature with the name and designation of the clinician clearly printed. All written interventions should be written on hospital paper with a space for a patient identifier. A signature bank must be held for all staff.

### UNIT B (MALE ADMISSION UNIT)

1. There must be a current clear policy available on the use of CCTV and appropriate signage displayed.
2. The placement of patients alone in an outside secure exercise area from which they cannot freely egress should be viewed as seclusion and the relevant policies and documentation applied.
3. There must be a communication facility for patients in seclusion.
4. The layout and design of the step down room should be addressed.

### UNIT 2 (MALE MEDIUM SECURE UNIT)

1. A community meeting should be introduced.

### UNIT 7 (MALE REHABILITATION UNIT)

2. There should be a written schedule for patient reviews.

