

Mental Health Commission Coimisiún Meabhair-Shláinte

ANNUAL REPORT | TUARASCÁIL BHLIANTÚIL

including the Report of the Inspector
of Mental Health Services 2005

2005

Book Four (of Six)

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Chapter 1

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KERRY GENERAL HOSPITAL**ACUTE PSYCHIATRIC UNIT**

Date of inspection: 27th June 2005

Number of beds: 50

DESCRIPTION

The acute unit in Kerry General Hospital is a 50-bed unit located on the ground floor of the General Hospital. It was opened in 1991. The occupancy is 32 beds and consideration is being given to reducing the bed numbers by six. There are five sector teams with admitting rights. The unit has two mixed wards – Valentia and Reask – with communal dining and seating areas. A significant practice development project (Refocusing Acute Psychiatry) is in place addressing 89 areas of practice change. This project aims to improve patient care and improve staff working lives.

REFERRAL

The main sources of referral are from the GP, self-referral or outpatients department. All admissions before 2000h are seen in the unit. All admissions after 2000h are seen in A&E. The NCHD assesses the patient prior to admission. The consultant psychiatrist is contacted if the patient is on a Temporary form.

PROCESS OF ADMISSION

There is an admission procedure. There had been an admission of a child under 16 years of age in the past. The child psychiatry team had clinical responsibility for that child. Admissions for detoxification are regular with admissions lasting five to seven days. The NCHD makes a full mental and physical examination on admission. Family and carers are consulted. The NCHD makes the decision to admit and will only phone the consultant psychiatrist if there is a doubt regarding the appropriateness of the admission. The consultant psychiatrist reviews the patient within 24 hours. Communication with the GP and family regarding admissions is informal. All patients are nursed in night clothes on admission.

There are two 6-bed observation dormitories on the ward. The nurse in charge allocates a key nurse to the patient according to the sector they come from.

CARE PLAN

Multidisciplinary care planning is in its infancy and is part of the Refocusing Acute Psychiatry Project. Due to the limited number of multidisciplinary team professionals, this has not been implemented in full. Planned discharges are discussed at team meetings. A discharge plan is sent to the GP and community mental health nurse on the day of discharge and this is copied to the file.

NURSING PROCESS

An adapted version of the Tidal model is in place, which contains a risk assessment overview. A key nurse system has been developed based on sector teams.

ACCESS TO THERAPY

There is limited access to social work, clinical psychology and occupational therapy. Referral is generally by the consultant psychiatrist. Patients are reviewed and seen by the medical team three times weekly. Patients are encouraged to self-refer to addiction and alcohol counsellors. As the unit is located in a general hospital, referrals are made to medical and surgical teams as needed.

ACCESS TO THERAPEUTIC PROGRAMMES

A programme is facilitated by occupational therapy, on a part-time basis, and a clinical nurse specialist, on a full-time basis, but this programme is not needed. There is no link between the programme and care plans. Patients are encouraged to attend.

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ECT

There is a dedicated consultant psychiatrist for ECT and there is an ECT suite. The nursing staff allocate a staff member to ECT on the day. ECT preparation takes place at the patients' bedsides. There is a waiting area and recovery room in place.

SECLUSION

There are two seclusion rooms on the unit, one in each ward. They were situated in the main corridor of each ward. The windows were covered in plastic glass and the doors opened inwards and outwards. There were observation panels in the doors. Each room has a number of risk features. The window frames on the doors were easy to take off and the beds, which were normal hospital-issue beds, were unsafe. Both rooms were bright and had adequate ventilation. There is a seclusion policy in place and a seclusion register. On the day of inspection, one seclusion room was being used as a single bedroom. There is no CCTV in place. Secluded patients must use the main toilet area.

CLINICAL RISK MANAGEMENT

There are policies and a pinpoint alarm system in place. The use of alcohol and illegal drugs on the unit is not a problem. Restraint by use of chairs is sometimes used to manage elderly confused patients. There are mandatory training courses for nursing staff. The Assistant Director of Nursing on site holds records of attendance. Each patient has a clinical risk assessment as part of the nursing process. There is a health board policy on clinical incident management. Audit pathways are under development.

UNIT MANAGEMENT

A number of patients have been transferred to a hostel in the catchment. In 2004 there were 27 transfers to the secure units in St. Finan's Hospital, Killarney. Twenty-one patients were returned to Tralee. Six people became new long-stay patients. The unit is open. A decision to lock the front door is taken by nursing staff in conjunction with the consultant psychiatrist and this is recorded. There is a

CCTV camera at the main door. The unit is also used for out-patient clozapine bloods. During the day there are ten nursing staff and one clinical nurse specialist on duty and six nursing staff on duty at night. Staff are centrally rostered from St. Finan's Hospital. All female staff wear uniforms, which are optional. There is a ward clerk available one day a week. A phlebotomist is available each morning or the NCHD will take bloods. On the day of inspection, there was no waiting list. Two patients were awaiting transfer to a nursing home. Visiting times are flexible and meal times are at set intervals.

SERVICE USER INVOLVEMENT

Patients are given verbal information as required. It was reported that there are unit leaflets developed for patients. There is a community meeting once a week and the advocacy service visits. Patients interviewed on the day of inspection reported that they had seen improvement over time and that nursing staff listened more. They reported that the main exit was often locked and that the activity programme was limited. Staff reported that there is a monthly survey of the patients and the results are discussed.

RECORDS

There are multidisciplinary files on this unit that every member of the team accesses. There are stickers with all the patient's details on each page of the case notes. The notes are legible and all disciplines enter their interventions in these notes. There is a section for each discipline. The files are tidy. There is no signature bank available but there is one on the drug cards, which could be incorporated into the files. The entries have the full name but no title of personnel. All entries are signed and dated. There are progress reports from social workers, occupational therapists and psychologists and the files contain treatment plans, which are reviewed weekly as part of the Refocusing Acute Psychiatry Project. The medication charts are all recently rewritten and are signed and dated. The file of a person secluded had a prescription of a two-hour seclusion. During the whole period of seclusion, which did last for two hours, he was sitting in a chair. The files of two Temporary patients were reviewed and clear reasons for detention and the dates of review were recorded.

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ENVIRONMENT

This was a 50-bed acute unit situated in the general hospital in Tralee. There was disabled access and the unit was all on the ground floor. It was a quite dull unit with very little natural light. Ventilation appeared to be a problem, especially on hot days. The main corridor of the ward was very dark and, although reasonably decorated, it was a dark colour. There were plenty of information boards containing up-to-date leaflets. There was a reception area in the main part of the hospital but not one for the acute unit. The bedroom areas were mainly large dormitories, which were split into high observation areas and general observation areas. Each of the bed areas had curtains around them and each bed area had its own wardrobe. The majority of dormitories had six beds, one had four beds and there were a couple of single rooms on each ward. Toilets and bathrooms were freely accessible and gender specific. There were overriding locks on each of the doors.

The dining area had sufficient space for all patients at one sitting. It appeared to be self-service and integrated between the two wards. The décor was of reasonable standard. The lounge area was very large and had hospital-issue furniture. It did not appear to be very comfortable. There was one TV in the corner. There was access to books and newspapers. There was one interview room available between the two wards, which was obviously very busy. It had an observation panel in the door and an alarm situated under the desk nurse stations were situated on both wards. They were freely accessible and open planned. This made confidentiality an issue and there also seemed to be limited space for report writing. It was reported that one of the wards had their handover in the ECT waiting area, which had open access. Staff were advised to find a more suitable location. The clinical room for each ward was fully equipped with medical equipment, cardio-pulmonary resuscitation equipment and oxygen. The ECT suite had a waiting area in an annex off the main corridor. The room itself was of a reasonable size and standard. There was adequate storage for patients' possessions.

ST. FINAN'S HOSPITAL, KILLARNEY

O'CONNOR UNIT (EAST WING)

Date of inspection: 28th June 2005

Number of beds: 19 male

DESCRIPTION

The O'Connor Unit is a single-storey, standalone building in the grounds of St. Finan's Hospital. It was formerly used as an admission unit prior to the opening of the acute unit in Kerry General Hospital in Tralee. Following the closure of St. Joseph's ward (an elderly care unit) on the 5th April 2005, four patients were transferred to the O'Connor Unit. Although the unit once functioned as a rehabilitation or transition unit prior to the transfer of patients to hostels in the community, it now provides continuing care to 18 men and it has one respite bed. The unit is an open unit and all the patients have Voluntary status. Two consultants who job-share have clinical responsibility for the unit. The respite bed is the responsibility of the Clinical Director.

REFERRAL

The unit has 18 patients who are long-stay patients in the hospital. The people who are admitted to the respite bed are usually referred to the consultant by their GP or by a community mental health nurse.

PROCESS OF ADMISSION

When a patient is admitted to the respite bed, he is assessed by a medical officer and seen on a fortnightly basis by a consultant. Most of the patients who use the respite service are already well known to the service.

CARE PLAN

There is no care planning system in use on this ward. Care is provided in response to the daily needs of the patients.

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NURSING PROCESS

The nursing model used on the unit was described as a self-care model. There is no formal risk assessment in use and there is no policy on observation. Staff are not required to wear uniforms and do not wear name badges.

ACCESS TO THERAPY

There is no rehabilitation team and no psychologists, occupational therapists or social workers visit the ward. A consultant visits the ward fortnightly and more often if required. Patients are reviewed by the consultant on a yearly basis. A medical officer visits the ward daily from Monday to Friday. Medical and surgical consultations take place at Kerry General Hospital and patients are transported there by taxi or hospital bus, accompanied by a staff member. Staff can access laboratory results quickly.

In March 2005, an assessment of all of the patients was undertaken using the Clifton Assessment for the Elderly. According to staff, the scores of all of the patients suggested that they would be suitable for high support hostel placements.

ACCESS TO THERAPEUTIC PROGRAMMES

There are no organised groups or therapeutic programmes on the ward. Six patients attend the industrial therapy unit, where they assemble cardboard boxes, work that is contracted in from a local factory. They receive a small payment for this work. One patient works full-time in a local factory. Some of the patients are retired. Others assist with cleaning of the unit. Some of the patients are not gainfully occupied during the day.

CLINICAL RISK MANAGEMENT

There was no policy on clinical risk management available on the ward. Nursing staff do not use personal alarms. There are no policies on alcohol and illegal drugs or giving medication without consent. There are policies on patients going missing and on the management of violent episodes. The personal belongings of some patients are occasionally

searched for specific reasons. This is done in consultation with the patient and his family. No form of mechanical restraint is used on this unit. Serious incidents are recorded and this data is collected for action and for audit purposes.

UNIT MANAGEMENT

Some of the patients from this unit have been transferred to St. Peter's, a locked ward, when their behaviour has been unmanageable. No separate record is kept of these transfers. The door to the unit is open during the day and locked at 2100h. There is central rostering of staff to the unit. The staff complement is two nurses in the daytime, one nurse from 1800h to 2100h and one nurse from 2100h to 0800h. There are three household staff on the unit daily and one porter but these staff are shared between the East and West Wing units. Newspapers, TV and radio are provided. There is no CCTV and the ward is not used for other purposes. The maintenance of the unit is poor. Phlebotomy services are provided by the medical officer. No specific information could be obtained about the training received by staff. Some courses are provided in the Nurse Education centre. There is no waiting list for the unit. Visiting times are flexible. Drinks and snacks are provided at set times during the day. Some patients go into the town or can purchase drinks from machines on the hospital. Meal times are 0830h, 1230h and 1630h are self-service from a trolley and there is a choice of food. The patients' money is managed in the general office of the hospital. Five of the patients are in receipt of €35 in patient comfort money. The social welfare books of two residents are held by family members. The balances in patients' accounts are sent to the unit every three months but patients do not get a breakdown of lodgements and withdrawals from their accounts. Five patients look after their own allowances of between €20 and €60 per week. All others have items from the hospital shop charged to the accounts. 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 residential setting.

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SERVICE USER INVOLVEMENT

Patients are not normally provided with information about treatment or medication and there does not seem to be any information available on patient's rights. There are very few information leaflets available. An advocate visits the ward. There is a complaints policy and a notice to this effect is posted on the unit. No community meeting is held on the ward.

RECORDS

The patients' files were tidy and manageable. The front cover contained the patient's name and hospital ID and date of birth. Entries were all dated and signed but not all signatures were legible nor was the person's title always used. The files contained treatment plans, progress reports and consultant reviews. According to staff, the patients are reviewed by the consultant at least once a year but this was not clear from the files. The nursing notes were signed, dated and legible but full names and titles were not always used. The files that were inspected contained no entries from social workers, occupational therapists or psychologists. No care plans or discharge plans were evident. No signature bank was available. A card index system was used for medication. The prescription and administration sheets were signed and dated but some of the signatures were not readily identifiable. The generic names of drugs were used. The discontinuation of medication was signed and dated.

ENVIRONMENT

The East Wing and West Wing units of the O'Connor Unit share the same entrance, main corridor, dining room, lounge and some shower and bathroom facilities. The dining room has space for all patients at one sitting. Meals are served at the tables by kitchen staff. The dining room and lounge are large and institutional. The seating is comfortable and radio, TV and newspapers are supplied. Staff provide some magazines but there are very few books available. The main corridor is dark and the décor of the unit is drab. The East Wing has no quiet room. There are three single bedrooms (including the respite bed) and three 4-bed rooms. The nursing office is quite small.

There is a clinical room but cardio-pulmonary resuscitation and suction equipment are kept in the main hospital building. A separate area is used for medication storage. This area has a hatch, which separates it from the corridor and medication is dispensed from here at set times during the day.

O'CONNOR UNIT (WEST WING)

Date of inspection: 28th June 2005

Number of beds: 12 female

DESCRIPTION

The O'Connor Unit is a single-storey, stand alone building in the grounds of St. Finan's Hospital. It was formerly used as an admission unit prior to the opening of the acute unit in Kerry General Hospital in Tralee. The West Wing unit is an open unit and provides continuing care to 12 female patients with an age range of 50+ to 80+ years. 11 of the patients in the West Wing have Voluntary status. One is a Ward of Court. Two consultants who job-share have clinical responsibility for the unit.

REFERRAL

Most of the patients are long-stay in the hospital. One patient was admitted in 2003 as she could no longer manage in the community.

PROCESS OF ADMISSION

Most patients have been transferred from wards that have been closed in the main hospital. Others have been transferred here from the acute unit.

CARE PLAN

There is no formal care planning system in use on this ward. Care is provided in response to the daily needs of the patients and is discussed on an informal basis with the consultant psychiatrist on a fortnightly basis.

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NURSING PROCESS

No specific nursing model is in use on the unit. A nursing care plan is drawn up based mainly on physical needs of the patients. This care plan is updated approximately every four weeks. There is no formal risk assessment in use. There is no policy on observation. The staff 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 visits the ward fortnightly and more often if required. Patients are reviewed by the consultant on a yearly basis. Physical examinations take place twice yearly. Weight is recorded on a monthly basis. A medical officer visits the ward daily from Monday to Friday. Medical and surgical consultations take place at Kerry General Hospital and patients are transported there by taxi or hospital bus, accompanied by a staff member. Staff can access laboratory results quickly.

ACCESS TO THERAPEUTIC PROGRAMMES

A Sonas programme, which consists of 45-minute sessions that include singing and music, takes place on the unit two or three times a week. Staff conduct relaxation and aromatherapy sessions. Five patients attend the industrial therapy unit, where they assemble cardboard boxes, work that is contracted in from a local factory. They receive a small payment for this work. One patient works in the main laundry. The remaining patients assist with cleaning of the unit and some help in the kitchen.

CLINICAL RISK MANAGEMENT

There was no policy on clinical risk management available on the ward. Nursing staff do not use personal alarms. There are no policies on alcohol and illegal drugs or giving medication without consent. There are policies on patients going missing and on the management of violent episodes. No form of mechanical restraint is used on this unit. Serious incidents are recorded and this data is collected for action and for audit purposes.

UNIT MANAGEMENT

One of the patients from this unit sleeps in St. Martin's locked ward each night. According to staff, this is at her own request. No separate record is kept of these transfers. The door to the unit is open during the day and locked at 2100h. There is central rostering of staff to the unit. The staff complement is two nurses in the daytime, one nurse from 1800h to 2100h and one nurse from 2100h to 0800h. There are three household staff on the unit daily and one porter but these staff are shared between the East and West Wing Units.

In conjunction with the college in Tralee, a number of housekeeping staff undertook a conversion course in order to train as Health Care Assistants and did six-month placements in the West Wing unit. Nursing students also do placements on this unit and some of the nursing staff are trained as preceptors. Lifting and handling and cardio-pulmonary resuscitation courses have been available for staff of this unit. Some staff have been trained in control and breakaway techniques. Literature is available on new medications. Newspapers, TV and radio are provided. There is no CCTV and the ward is not used for other purposes. The maintenance of the unit is poor. Phlebotomy services are provided by the medical officer. There is no waiting list for the unit.

Visiting times are flexible. Drinks and snacks are provided at set times during the day and also on request. Some patients go into the town or can purchase drinks from machines in the hospital. Meal times are 0830h, 1230h and 1630h. Meals are self-service from a trolley and there is a choice of food. Dietary needs are taken into account. The patients' money is managed in the general office of the hospital but the patients are asked how much money they want each week for personal spending. Eight of the patients manage this money by themselves. The money of the other patients is held in the nurses' office. The balances in patients' accounts are sent to the unit every three months but patients do not get a breakdown of lodgements and withdrawals from their accounts. There are no patients awaiting appropriate discharge placements although it was the opinion of staff that about eight of the patient group could function well in a hostel setting.

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SERVICE USER INVOLVEMENT

Patients are given verbal information about treatment or medication but there does not seem to be any information available on patient's rights. There are very few information leaflets available and there is no notice board. There is a complaints policy and a notice to this effect is posted on the unit. There is no community meeting held on the ward but informal meetings take place about outings.

RECORDS

The patients' files were tidy and manageable. The front covers contained the patients' names and hospital IDs and dates of birth. Entries were all dated and signed but not all signatures were legible nor was the person's title always used. The files contained treatment plans, progress reports and consultant reviews. According to staff, the patients are reviewed by the consultant at least once a year but this was not clear from the files. The nursing notes were signed, dated and legible but full names and titles were not always used. The files that were inspected contained no entries from social workers, occupational therapists or psychologists. No care plans or discharge plans were evident. No signature bank was available. A card index system was used for medication. The prescription and administration sheets were signed and dated but some of the signatures were not readily identifiable. The generic names of drugs were used. The discontinuation of medication was signed and dated.

ENVIRONMENT

The East Wing and West Wing units of the O'Connor Unit share the same entrance, main corridor, dining room, lounge and some shower and bathroom facilities. The dining room has space for one sitting. Meals are served at the tables by kitchen staff. The dining room and lounge are large and institutional. The seating is comfortable and radio, TV and newspapers are supplied. Staff provide some magazines but there are very few books available. The main corridor is dark and the décor of the unit is drab. The West Wing has a quiet room. There is no single bedroom. There is one 4-bed room, two 3-bed rooms and one two-bed room. Patients have their

own wardrobes and lockers, the drawers of which can be locked. A laundry room is available for patients to do their own laundry if they wish. In order to access the shower and bathroom, the female patients have to pass through a corridor, which the male patients from the East wing have access to. Given the layout of the unit, this situation is not satisfactory and affords little privacy to the female patients. The nursing office is quite small. There is a clinical room but cardio-pulmonary resuscitation and suction equipment are kept in the main hospital building. A separate area is used for medication storage. This area has a hatch which separates it from the corridor and medication is dispensed from here at set times during the day. The overall impression of this unit is that there is a shortage of space and that the unit is quite cramped.

OUR LADY'S WARD

Date of inspection: 28th June 2005

Number of beds: 16

DESCRIPTION

This unit is described as a care of the elderly ward. On the day of inspection, there were four Wards of Court, one Temporary patient and one Person of Unsound Mind (PUM).

REFERRAL

The acute unit in Tralee is the source of referral. Referrals are assessed in Tralee, and the decision to admit is made by a consultant psychiatrist.

PROCESS OF ADMISSION

There are very few admissions to this service. The consultant psychiatrist assesses the patient, a physical examination is carried out and a collateral history is taken. The consultant makes the final decision on the admission of patients. There is currently one person with a moderate intellectual disability on the unit.

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CARE PLAN

It was reported that there are nurse-led care plans but there was very little evidence to support this in the files. There are written interventions under the heading of Care Plan Review but there was no evidence of any current up-to-date care plans. There is no key worker system and no evidence of participation by the patients in care planning. There are few discharges from this unit.

NURSING PROCESS

It was suggested that the Roper Logan Tierney model was in use on this unit but there was no evidence of this.

ACCESS TO THERAPY

There was no access to a psychologist, occupational therapist or social worker. There is one consultant psychiatrist, who has responsibility for this unit. It was reported that there is a weekly review of the patients, who are selected by the nursing staff, although there did not appear to be any written evidence to support this. The medical officer visits the ward daily to review any physical needs. There is also a physiotherapist who visits the unit twice a week and there is access to a chiropodist and dentist.

ACCESS TO THERAPEUTIC PROGRAMMES

Reminiscence therapy, videos and Sonas programmes are organised on the ward. There are also occasional trips out.

CLINICAL RISK MANAGEMENT

There are policies on infection control. There is no alarm system in operation as this was deemed to be unnecessary. There is a policy in place regarding patients missing from the ward. There is some mechanical restraint used but there are no policies to support this. It appears that cot sides are used for the majority of patients and there were two patients strapped into chairs on the day of inspection. There is

no seating assessment carried out by an occupational therapist. The staff are trained in de-escalation techniques and in cardio-pulmonary resuscitation and manual handling. Some are trained in control and restraint. There is some in-house training facilitated by the Tralee IT. There are no risk assessments documented in the patient's charts. Forms are available for the reporting of serious incidents.

UNIT MANAGEMENT

There are no temporary or long-term transfers to other units. There are minimal activities on the unit and patients are accompanied off the unit by staff. There is an open door policy but the door is locked at night and on occasions when there is a risk of a patient going missing. There are four staff on duty during the day and two at night. The unit generally has a core team of staff but there is central rostering to cover annual leave and sickness. There is one household member of staff on duty during the day. All the staff wear uniforms.

Visiting times are flexible. Meals are at set times and there is access to drinks and snacks in between meals. The patients' money is managed by the general office although two people do have free access to their accounts and regularly withdraw money. The Tralee IT offer a range of training from manual handling to venepuncture.

SERVICE USER INVOLVEMENT

There is minimal service user involvement on this ward. There is a complaints policy and complaints are usually dealt with at ward level. There was no evidence of leaflets regarding complaints. The views and opinions of patients are sought informally and those of relatives and carers are sought on visits. The advocacy service visits St. Finan's on a regular basis.

RECORDS

The records contain the patient's name and ID. The files are legible and are reasonably tidy but there is no signature bank. Entries have name only but they are dated and signed. There were no progress reports from social workers, occupational therapists or

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psychologists and no comprehensive treatment plans. Separate nursing files contain progress reports that pertain to care plans that don't seem to exist.

ENVIRONMENT

This was a 16-bed care of the elderly ward, situated in the grounds of a psychiatric hospital. It was a large open-plan ward that had been recently redecorated and had a regular maintenance programme. Disabled access was limited and the toilets were very small and not wheelchair accessible. The lighting was of a good standard and ventilation appeared to be good. There is one large dormitory but there were no curtains around the beds at the time of inspection due to the redecoration. The curtains were to be replaced once the redecoration was finished. There was wardrobe space and everybody had their own personal clothing. Toilets and bathroom décor was reasonable. There were specific bathing times and there were overriding locks on the doors. The dining area doubled up as a lounge area. There was space for one sitting and there was a reasonable choice in the menu. The lounge area was reasonably well furnished and it had a cosy area around the TV. The nurses' station was situated just off the day room and there was also one in the dormitory. There appeared to be adequate space for report writing. The clinical room was situated off the main corridor and contained the necessary equipment. There was reasonable storage space.

ST. MARTIN'S UNIT

Date of inspection: 28th June 2005

Number of beds: 10

DESCRIPTION

St. Martin's Unit is an 8-bed locked female secure unit located on the ground floor of St. Finan's Hospital. The average age of the patient group is 40. The youngest patient is 24 years old. On the date of inspection, there were three patients on Temporary status and four on Voluntary status. The unit has capacity for ten patients. There is one lodger each evening from O'Connor Unit. The unit is the clinical responsibility of a named consultant psychiatrist.

REFERRAL

All referrals are from the acute unit in Tralee and are made through a named consultant psychiatrist. Patients are transferred when their behaviour is unmanageable in the acute unit in Kerry General Hospital.

PROCESS OF ADMISSION

All decisions to admit are made by a consultant psychiatrist. The clinical notes are transferred from the acute unit to St. Finan's Hospital. On arrival, the consultant psychiatrist reviews the patient and an initial plan is identified. All patients are nursed in night clothes when they are first admitted. There is one level of observation, which is general observation. Not all patients have a key nurse.

CARE PLAN

The care plan transfers from the acute unit. There is no multidisciplinary team input into this unit. There are no active discharges.

NURSING PROCESS

There is no nursing model in place and there were no care plans. There is no key nurse, no risk assessment completed and no identified levels of observation.

ACCESS TO THERAPY

There is no access to an occupational therapist, clinical psychologist or social worker. The consultant psychiatrist visits the unit once a week. The GP is available each morning and out of hours an on-call primary care service is available. There are four staff nurses on duty during the day and two on duty at night. There is one household staff member.

ACCESS TO THERAPEUTIC PROGRAMMES

There is no individual therapeutic programme in place. Residents can leave the unit unaccompanied to

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use the hospital shop and canteen. They can also go to industrial therapy on site. The social activities officer visits the unit each Wednesday.

SECLUSION

There is no seclusion room. However, although not defined as seclusion, patients are locked into their rooms at night at 2000h with only access to a commode until 0800h the following morning.

CLINICAL RISK MANAGEMENT

Staff carry pinpoint alarms, with a response coming from Our Lady's Unit. Patients' belongings are searched in their presence. Physical restraint is rarely used. There is no mechanical restraint in use. Nursing staff are offered mandatory courses on a rota basis. There is no formal risk assessment on each patient.

UNIT MANAGEMENT

The unit, which is locked continuously, has two exits and two buffer zones. Each night a female patient from O'Connor Unit is lodged to the unit and locked into a single room. Female nursing staff wear uniforms. Male nursing staff wear casual clothes. There is no waiting list for admissions. The maximum number of patients is ten. The hospital maintenance staff are responsible for the upkeep and repairs. Official visiting time is before 1800h but visitors may visit at other times with the agreement of staff. Meals are at set intervals. All patients receive €35 comfort allowance each week. This is managed by nursing staff. Patients' cigarettes are managed by staff. Each patient has a yearly allowance of €350 for clothing. This sum of money must be spent in the hospital shop.

SERVICE USER INVOLVEMENT

Patients are only given information if requested. There is no information available on rights under the 1945 Mental Treatment Act and there are no community meetings. The Irish Advocacy Service does not visit the unit but the advocate is available at set times in the hospital.

RECORDS

The medical records were in order and contained treatment plans. The nursing notes have no care plans. Recording was ad hoc and there was no signature bank available. The drug card index was in order but nursing staff sign only their initials when medications are dispensed.

ENVIRONMENT

There were seven single rooms and one double room. The rooms were heated by fan heaters positioned high on the walls. There was a single window in each room that had lockable shutters. Commodes were placed in each room at night and the door was locked. There was no bell calling system for calling nursing attention at night. Some residents had personalised their areas with photos. There was an external garden space that was enclosed by a tall green railing. The dining room was arranged to have each person sit in isolation at meal times. The chairs were plastic. There were no extractor fans in either the kitchen or the internal smoking room.

ST. PAUL'S UNIT

Date of inspection: 28th June 2005

Number of beds: 10

DESCRIPTION

This is a long-stay, care of the elderly unit located on the ground floor of St. Finan's Hospital. There are seventeen male patients. The unit is locked. On the day of inspection, there were three patients on Temporary status, two Wards of Court and all others were of Voluntary status.

REFERRAL

All referrals to the unit must be cleared with the identified consultant psychiatrist. The unit has access to a GP service daily during normal working hours. Out of hours medical problems are referred to the on-call primary care service. There are no defined levels of observation and there is no key nurse system.

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CARE PLAN

There is no evidence of multidisciplinary care planning in place.

NURSING PROCESS

There is no nursing model in use on the unit. There are no identified observation levels. There are no formal risk assessments.

ACCESS TO THERAPY

There is no access to an occupational therapist, clinical psychologist or social worker. The consultant psychiatrist visits the unit weekly. There is access to a physiotherapist as required and the chiroprapist visits on a weekly basis.

ACCESS TO THERAPEUTIC PROGRAMMES

One man attends a workshop on the grounds of the hospital. All others remain on the unit each day. There is no therapeutic programme on the unit and this results in a non-stimulating environment.

CLINICAL RISK MANAGEMENT

There is no specific unit policy. Risk is defined on clinical judgement. Due to the elderly nature of the population there is a high risk of falls among some patients. There is no alarm system in place. Mechanical restraint is in use for one resident. He is seated in a Buxton chair with a table in front. This is documented in the medical notes. Cot sides are also in use. There is no audit of incidents in place.

UNIT MANAGEMENT

The unit is locked to prevent wandering. There is central rostering but there is a high level of consistency of staffing. Meal times are at set intervals. Drinks are provided during the day for patients. Maintenance requests are to the central hospital maintenance department.

SERVICE USER INVOLVEMENT

Patients receive no information regarding their rights under the 1945 Mental Treatment Act. Advocacy services do not visit the unit. Comfort money of €35 a week is pooled and used to buy cigarettes, chocolate and drink by staff in the hospital shop. Patients do not have access to their own money or consent to the above procedure.

RECORDS

The medical and nursing notes are combined in a single file with separate sections. The documentation standards are poor and the names were often illegible. Patient identifiers on each page are not consistent. The GP completes a twelve-monthly physical review. A six-monthly mental state review is undertaken for Temporary patients. Nursing notes are written as required but there is no set standard. The medication sheets are not rewritten every six months. The signatures and initials are illegible. There is no signature bank in place.

ENVIRONMENT

The unit was located on the ground floor. There were five single rooms, one en-suite and a large dormitory area. All of the rooms were lacking any personal belongings. The dormitory area was particularly dark. The dining area was located on the veranda. Staff had the necessary fully accessible showers hoist to aid moving and handling the more dependent patients. There was an internal smoking room with extractor fan.

Patients interviewed reported being satisfied with the food. However, they reported that the days were very long and many were unable to concentrate on the TV.

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ST PETER'S UNIT

Date of inspection: 28th June 2005

Number of beds: 10

DESCRIPTION

This unit is described as a 10-bed locked unit but on the day of inspection there were 11 patients. There were three Temporary patients, one Ward of Court and seven Voluntary patients.

REFERRAL

The sources of referral for this unit are the acute unit in Tralee and An Garda Síochána. If the consultant psychiatrist responsible for the patient in the acute unit is of the opinion that the patient needs to transfer to a secure facility he or she will discuss this with the consultant psychiatrist for St. Peter's unit. In emergency situations, a consultant psychiatrist can authorise transfer directly.

PROCESS OF ADMISSION

No children under 16 years are admitted. There are people with a moderate intellectual disability and there are three in this category at present. There are no admissions for detoxification or social crisis. Persons being transferred from the acute unit are assessed by one of the medical staff in the acute unit prior to transfer. In the case of admissions through An Garda Síochána, the consultant psychiatrist on call assesses the patient on admission. A physical examination is carried out and a collateral history is taken. The consultant psychiatrist makes the decision to admit. The GP is not informed of an admission, but the next of kin is informed. The initial treatment plan is explained by the consultant psychiatrist. Patients may be nursed in pyjamas during the day on initial transfer.

CARE PLAN

There are no care plans on this unit.

NURSING PROCESS

There are no nursing models used. There is no key worker system or any formal risk assessment carried out.

ACCESS TO THERAPY

There is no access to a psychologist, occupational therapist or social worker. The medical officer addresses the patients' physical needs. The consultant psychiatrist, the medical staff and nursing staff review the patients on a regular basis.

ACCESS TO THERAPEUTIC PROGRAMMES

There does not appear to be any therapeutic programme on this unit.

SECLUSION

There is a seclusion policy and a register, which is kept up to date. Very little seclusion is used on the unit, the last episode being in January of the current year. The room itself is clean and safe, though there is a need for ventilation to be installed. There is an observation panel in the door and there is good visibility throughout the room. Refractory clothing is not used nor is there use of CCTV although staff stated that they would like CCTV in the seclusion room.

CLINICAL RISK MANAGEMENT

There is a policy on infection control but there does not appear to be any clinical risk policy. There is an alarm system in operation and there are policies in place on alcohol and illegal drugs, patients going missing from the unit, the management of violent episodes, rapid tranquillisation and searching patients' belongings. There is no mechanical restraint in use but there is a physical restraint policy and staff are trained in crisis prevention intervention techniques, including de-escalation and breakaway techniques. The staff are trained in cardio-pulmonary resuscitation techniques but it was reported they

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need an update. No clinical risk assessment is documented in the patients' charts. Serious incidents forms are in use but staff reported that there is no feedback on these completed forms. There doesn't appear to be any audit carried out on serious incidents.

UNIT MANAGEMENT

Patients are not transferred temporarily to other units and any long-term transfer on a rare occasion is to the Central Mental Hospital. There are limited activities available on the unit. There are some off-site activities. Each patient has a "parole" status which allows them certain amounts of time off the unit either escorted or unescorted. The unit is always locked. There is no CCTV. There are four nursing staff on duty during the day and two at night. Staff feel that there should be three staff on duty at night. The unit is rostered with regular staff. All the staff have worked on the unit for a long time. It was highlighted that three patients are suitable for placement elsewhere in a non-secure setting. Limited maintenance is carried out on the unit although it is in a reasonable state of repair.

Visiting times are flexible, meal times are set and there is availability of snacks and drinks in between meals. Patients have an account with the general office and sign requisitions to get their money.

SERVICE USER INVOLVEMENT

It is very unusual for the service user to be involved in their own care. There does not appear to be any information on treatment or therapies though the doctor explains the rights of a Temporary patient. There is a complaints procedure but there is no access to advocacy.

RECORDS

The patient's name and ID was available on all pages and the notes were legible and reasonably tidy. However, there was no structure to the notes and there were a number of loose pages. There was no signature bank. All entries were signed and dated but titles were not used. Some of the files had progress

reports from other professionals, usually a social worker. They contained treatment plans, which were reviewed regularly by the consultant. The consultant reviews at least weekly and the medical officer reviews as needed. Medication sheets were recently rewritten and were signed, dated and legible. Discontinuation of medication was signed and dated.

ENVIRONMENT

This was a 10-bed unit in the grounds of a psychiatric hospital. There was adequate lighting and reasonable ventilation. The standard of décor was reasonable and the noise levels were appropriate. There were no information boards. There was a designated visitors' room and staff suggested that there was need for CCTV to prevent contraband items being given to patients. There was access to a small, enclosed garden. Unfortunately this area wasn't made bigger. The bedroom areas comprised some single rooms and a dormitory. There was no privacy in the dormitory as there were no curtains around the beds and it was overcrowded due to the extra bed. One of the single rooms had paint peeling off the walls and the walls appeared to be damp.

The patients' property was stored in a central cupboard; there were no wardrobes for patients. The reason given for this was that other patients would either steal the clothes or throw them out the window. Some of the patients did have their own personal belongings in their rooms. One had a TV and one had a hi-fi system. There was free access to toilets but the bathrooms were locked. The décor was reasonable and there were overriding locks on the doors. The dining area had space for one sitting and it was reasonably well furnished. There were plastic knives, forks and plates used. There was one TV lounge area, which was very large but sparsely furnished.

The nurses station was situated centrally within the unit. It doubled as the clinic room. Some drugs and equipment were stored in this room, which was quite small. It did appear to be confidential but there was limited space for report writing. Files and records were stored in the nurses' station. There was a small amount of storage area within the unit.

The seclusion room was situated in the main corridor of the unit. There was one room dedicated for

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seclusion and another room had been adapted and could be used for seclusion. The designated seclusion room was slightly smaller than the other room but appeared to be risk-free. There was an observation panel in the door and the windows could be covered with a wooden boarding if necessary. There was a good standard bed within the seclusion room. The main issue for the unit with regard to seclusion was the lack of ventilation. This needed to be remedied. The other room that was designated to be used for seclusion if necessary was slightly larger and was being used as a bedroom.

SECOND INSPECTION: ST. FINAN'S HOSPITAL, KILLARNEY

St. Finan's Hospital, Killarney was inspected on June 28th 2005. Following inspection the Inspectorate had a number of concerns about the care and treatment of some patients in St. Finan's Hospital. These were as follows:

1. The locking of doors of bedrooms at night.
2. The absence of adequate care planning/nursing care models.
3. The lack of a key worker system.
4. The absence of psychiatric and medical review of patients on the ward.
5. The employment rights of patients attending work opportunities.

The senior management team was notified in writing of these concerns and asked to address these issues. They were also informed that an unscheduled second inspection would take place within three months to ensure that these issues were addressed. The second inspection of St. Finan's Hospital was completed on the 20th and 21st of February 2006.

Prior to the second inspection, the Clinical Director reported that the practice of locking patients into their bedrooms at night was addressed immediately after our initial inspection. This practice was continuing for two patients on St. Martin's Ward. The Inspectorate remained concerned that there were no formal risk assessments completed to address the issue. The Inspectorate found that there was

evidence of plans to introduce care planning into the elderly care wards, St. Martin's Ward and St. Paul's Ward. There was no time-scale available for the commencement of this task. There was no evidence of care plans on the O'Connor Unit (Male). There was no key worker system on any of the wards. The Inspectorate found that there was adequate review of the physical and psychiatric status of patients. With regard to the final issue of concern the Inspectorate was unable to draw a conclusion on the matter. It is a complex issue that requires a coordinated response from various governmental departments.

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

The Mental Health Commission requested a report from the senior management team by June 2006 in relation to issues numbered one to four. The commission is to write to the Department of Health and Children in relation to the employment rights of individuals in sheltered workshops.

BRIDGE VIEW, KERRY

Date of inspection: 29th June 2005

Number of beds: 15 beds

DESCRIPTION

Bridge View is a unit with 24-hour nursing staff supervision for men with a moderate or severe intellectual disability. It is situated on the outskirts of the town. The unit is divided into three separate five-bed units. On the same site is Arch View, an identically designed unit, catering for people with an intellectual disability.

REFERRAL

The residence receives referrals from all over the county. GPs refer to the consultant psychiatrist, who then makes an assessment. This residence caters for people with profound and moderate learning disability and generally has a static population.

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PROCESS OF ADMISSION

There is an admission policy in existence. Profound learning disability is the main reason for admission: the individual usually cannot cope either at home or in independent living. On admission, the staff observe the resident and provide appropriate interventions. A physical examination is carried out and a collateral history is taken. A decision to admit rests with the consultant psychiatrist. There is some communication with family members who wish to be in contact with the residence. The consultant psychiatrist carries out a review each week but there is no treatment plan documented in the notes.

CARE PLAN

There were no care plans in use at the time of inspection, although the nurse in charge of the unit is working with the Practice Development Department to initiate a care planning system within the residence.

NURSING PROCESS

It is planned to implement a nursing process in line with the care planning process.

REHABILITATION TEAM

There is no access to a clinical psychologist or occupational therapist but there is occasional input from a social worker. There is an activation unit attached to the residence. One consultant psychiatrist has responsibility for the residence. There is a weekly review by the consultant and an NCHD carries out physical examinations of the residents.

INVOLVEMENT IN REHABILITATION PROGRAMMES

It was stated that a number of programmes have been tried but unfortunately have failed due to the profound nature of the clients' learning disability. It was reported that the social and recreational therapist provides programmes in the activation centre.

CLINICAL RISK MANAGEMENT

There is a policy on risk management available.

UNIT MANAGEMENT

Residents are never temporarily or permanently transferred to other units. The nursing staff are qualified mental health nurses and it is noted that there are no learning disability trained nurses in the residence. There are five staff on duty during the day, which includes a nurse providing one-to-one nursing, and two nurses on duty at night. This seems to be an inadequate number given to the profound learning disability of the residents. The unit has its own regular group of staff and there is central rostering of other staff to cover annual leave and sickness. There are three household staff on duty during the day, one in each unit. The ethos of the residence is to meet the needs of the client, provide a home environment and the appropriate care. There is no formal process of induction for residents or staff but there are appropriate policies and procedures available. The dress code is casual. There is no waiting list for this residence and there are few residents discharged. The maintenance is provided from the hospital maintenance department in St. Finan's Hospital.

HOUSE RULES

There are no formal house rules within this residence. There is open visiting. The residents are not allowed to leave the residence unsupervised due to the extent of their learning disability. They are, however, taken out for walks and occasional outings. Meals are prepared in the main hospital and delivered to the residence. There is no involvement of the residents in the menu planning.

FINANCE

Residents' money is managed by the staff in the general office of St. Finan's hospital. There is a requisition system in place, by which the staff in the residence request money for the residents. It was reported that residents are in full receipt of benefits and pay some money towards their keep.

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RECORDS

The resident's name and identification was on all pages of the file and the records were legible and tidy. There is no signature bank available. Entries have the full names and titles of personnel and they are signed and dated. There were no progress reports from other health professionals – there is minimal multidisciplinary input into the residence. There is no treatment plan contained in the file and the main source of regular review is the annual review. Medication charts were all in order, signed, dated and legible.

ENVIRONMENT

This is a 15-bed unit split into three smaller 5-bed units. Although the unit was built four years ago there were a number of design faults, which had been reported. A number of concerns were expressed to the Inspectorate regarding hazards identified within the residence. It was stated that, to date, no action had been taken to eradicate these risks. It was reported that the HSE had a regular maintenance programme in place. The hygiene and décor of the residence was good. Unfortunately, a lot of the furniture that was bought initially had been destroyed by some of the more disturbed residents and this had not been replaced. Appropriate furniture needs to be bought to meet the needs of this client group. There were three single bedrooms and one double bedroom in each of the smaller units. Each unit also contained a lounge area, a kitchen and sufficient showers and toilets. There was adequate space for personal storage in each of the units. There were certain safety issues within the residence that need to be addressed.

STAFF TRAINING

There is training available for the staff but releasing staff from the residence to attend the training is an issue. Training is provided in manual handling, cardio-pulmonary resuscitation and infection control. One member of staff has been trained in control and restraint techniques. It was reported that staff self-fund a number of training courses due to the lack of training support from the hospital management.

ARCH VIEW UNIT

The main issue for the Arch View unit was the high number of assaults on staff. There are only two nursing staff, who are continually rostered to the unit. The other staff are centrally rostered to the unit. It was reported that the residents respond better to staff that they are familiar with. Arch View has 10 male residents and five female residents. The women are in a separate unit with female staff. A number of the residents attend the activation unit on site.

CHERRYFIELD HOUSE, KILLARNEY

Date of inspection: 30 June 2005

Number of beds: 20

DESCRIPTION

This is a 20-bed, two-storey residence located on the grounds of the former Isolation Hospital, Killarney. The profile of the residents is mixed. The age range is from 20 to 75 years. There are five residents under 30 years of age. The residence opened in 1996 and is owned by the HSE. One consultant psychiatrist has admitting rights.

REFERRAL

All referrals to the residence are through a named consultant psychiatrist.

PROCESS OF ADMISSION

All admissions are for rehabilitation. There are no written admission policies or inclusion or exclusion criteria. In the past, residents had been admitted on trial status. The initial assessment is completed in the acute unit. The medical/nursing file transfers with the resident. The consultant psychiatrist visits weekly to review residents.

CARE PLAN

There are no multidisciplinary care plans in operation.

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NURSING PROCESS

The nursing staff are introducing new care plans based on an adapted nursing model.

REHABILITATION TEAM

There is no dedicated rehabilitation team. The consultant psychiatrist visits weekly or more often if required. All residents are registered with the local GP, whom they attend for yearly physical examinations. There is a CNM2 and staff nurse on duty each day with two staff nurses at night. There is one household staff member.

INVOLVEMENT IN REHABILITATION PROGRAMMES

The majority of residents attend programmes off site. These vary from open employment with a job coach assistant, training centres under the direction of the Kerry Mental Health Services and industrial therapy in the hospital. Four residents remain in the residence during the day and have responsibility for different household tasks.

CLINICAL RISK MANAGEMENT

Residents' rooms or belongings are not searched. There is no problem with the inappropriate use of alcohol or the taking of illegal drugs. Staff are on a central roster for attendance at cardio-pulmonary resuscitation and student nurse training.

UNIT MANAGEMENT

The residence is staffed by core nursing staff and one domestic staff. The staff are rostered centrally from St. Finan's Hospital. There is a friendly open atmosphere. Staff are in smart casual clothes. There is a waiting list for placement. There were no discharges last year. All requests for maintenance are followed up. Additional household staff are rostered if required.

HOUSE RULES

There are unwritten house rules. These are designed by nursing staff and reviewed at fortnightly community meetings. Residents have access to a front door key and can lock bathroom and bedrooms, although the locking of bedrooms is not encouraged. Residents are informally asked to inform staff when they are leaving the building. Meals are prepared in the County Home and transported to the residence. The residents are involved in menu planning as part of a healthy eating initiative. Residents have free access to a kitchenette to make hot drinks.

There are four single rooms and eight double rooms. There is no set bedtime and residents can sleep on at the weekends. Many residents go on weekend leave. All residents have bank or credit union accounts. They collect and lodge money independently but nursing staff hold all social welfare books. Nursing staff will only manage money if asked. Residents buy and wash clothing independently. There is an informal rota for using the utility room. Residents access local services, church, bingo and coffee shop and all facilities are within walking distance. The residence has access to a minibus for outings. The Kerry Mental Health Association contributed to the purchase of the minibus.

SERVICE USER INVOLVEMENT

Residents receive verbal information on all therapies and treatments. All residents are registered to vote in the local area. Complaints are dealt with at local level and there is information available on accessing the HSE Area complaints system. A community meeting is held fortnightly.

RECORDS

Residents have never requested access to their files. The files reviewed on the day of inspection had evidence of regular mental state reviews by the consultant psychiatrist. The medical and nursing notes are in one file and are identified by colour. The files were legible and tidy. There were no signature banks available and a patient identifier was not present on each page. The medical card index was of

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good standard. The medications are rewritten every three to six months. No residents are currently self-medicating. The chemist fills the prescriptions, residents give them to nursing staff, who dispense the medications daily.

ENVIRONMENT

The building was an old two-storey convent, which was in a poor state of repair. The downstairs' level accommodated the Kerry Mental Health Association development officer and a group home nursing staff member. The beds and furniture were in need of upgrading. There was adequate storage for each resident and the building had an internal smoking room with no extractor fan. Plans were being developed to build a new 15-bed high support residence. Residents' views were being included in the design stage. It was hoped the new building will open in October 2006.

ISLAND VIEW, KERRY

Date of inspection: 29th June 2005

Number of beds: 13

DESCRIPTION

Island View is a 13-bed residence with 24-hour nursing staff supervision, with one respite bed. It is situated on the outskirts of town and opened in 1993. On the day of inspection, there were eight male residents and five female residents.

REFERRAL

The main sources of referrals are a day hospital on site and the acute unit in Tralee. The consultant psychiatrist receives a referral and assesses the patient. The referral is then discussed in detail at a case conference, which is attended by staff of the residence.

PROCESS OF ADMISSION

There is an admission policy in existence, with a main focus on the initial stages of admission to the

residence. The exclusion criteria include a recent history of violence and mobility problems, due to the fact that the unit is upstairs and there is no lift. The reasons for admission include promotion of independent living and the reintroduction of people to the community. There is a programme linked to the local day centre, which is situated close to the residence. Although this residence does not take admissions as alternatives to acute admission, it occasionally takes people for respite care. It does not admit people for detoxification and on a rare occasion admits somebody for a social crisis. Residents are not formally assessed on their admission to the residence. There are few admissions to the residence due to the fact that the residents are elderly and there are few referrals onwards. The resident is reviewed within one week of admission. The initial treatment plan is documented and a key worker is allocated.

CARE PLAN

There are nurse-led care plans, which are quite basic. A number of care plans are out of date and have not been reviewed. There are progress reports. There is no documented participation by the residents or family members in any of the care plans. There were no discharges last year. There are currently one or two people identified as ready for lower level of support accommodation. If a resident is ready to move on, GP, family, community team and voluntary services involved in the resident's care are notified.

NURSING PROCESS

There is no nursing model in use and staff expressed concern about this. Risk assessments are not carried out on any of the residents although the Inspectorate was informed that Kerry Mental Health Services are developing a risk assessment policy.

REHABILITATION TEAM

There is no access to a psychologist, occupational therapist or social worker. An art therapist visits the day centre regularly. There is one consultant psychiatrist who conducts a fortnightly review within

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the residence. Each resident is reviewed on a six-monthly basis. Four GP practices have patients in the residence and they visit on a regular basis. An annual physical examination of all residents is carried out.

INVOLVEMENT IN REHABILITATION PROGRAMMES

There is no evidence of any needs-based individual programmes. Emphasis is placed on the residents attending the local day centre and any leisure activities that are available. The residents attend the day services unaccompanied.

CLINICAL RISK MANAGEMENT

There is a policy on risk management available. There is an alarm system in the residence. There are policies on alcohol and illegal drugs and residents missing from the residence. It is not deemed necessary or appropriate to search residents within this residence. Any serious incidents are recorded on the appropriate forms and the Assistant Director of Nursing is informed.

UNIT MANAGEMENT

There are no transfers to other units. The residence is not used for any other purpose. The staff in the residence are all qualified nurses and there are two staff on duty at all times. The unit is also a student nurse placement centre. The unit is self-staffing. The ethos of the unit is to promote independent living. An annual report is compiled. There is a checklist process for induction of residents and staff and there are policies and procedures present. The dress code is casual. There is currently no waiting list. The maintenance of the residence is carried out by the HSE Southern Area, but this can be problematic due to the distance of the residence from the main centre in Tralee.

HOUSE RULES

The staff design the house rules and they focus on etiquette, smoking and alcohol. They are reviewed as necessary. Visiting times to the residence are flexible

but there is no visiting after 2100h and visitors are asked to report to the nurse in charge. Residents do not have a front door key. It was stated that the door is open most of the time. Residents can lock the bathroom door but not their bedroom doors. Residents are allowed to leave the residence unsupervised and are asked to inform the nurse in charge when they are leaving and what time they are due back. There is no requirement for the residents to be out during the day.

The meals are prepared in the main kitchen in the hospital. There are some kitchen facilities within the residence where residents can make snacks and drinks. Residents are not required to go to bed at certain times. They are not allowed to smoke in their bedrooms and the staff decide who share rooms. Visitors are not allowed to stay overnight and the residents cannot choose to stay in a single room. They are required to be up for breakfast but some patients prefer to stay in bed and this is allowed. All the residents have their own bank accounts. Some manage their own finances. A number are unable to manage their own bank accounts so the staff assist them. There is a policy governing the financial arrangements, which are regularly audited. It was reported that residents are in full receipt of all benefits and these are paid into their own bank accounts. Currently residents are not being charged for rent within the residence.

The HSE provides the furniture and fittings for the residence although residents can buy their own furniture if they so desire. They buy their own clothes, which are bought in local shops. Residents have supervised access to the utility room. It was explained that a number of them do know how to use the washing machines and need some supervision for this process. It was reported that the residence is integrated with the local community. The residents attend sporting fixtures and rowing regattas. Also the day centre and training centre grow a number of bedding plants and vegetables, which they sell to the local community. The local facilities are all within walking distance and there is limited public transport. The residence has the use of a bus.

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SERVICE USER INVOLVEMENT

There is limited information available for the residents on their treatment and therapies. They are only given information on request. There was little evidence of information leaflets or information on national health initiatives. It was reported that there were no complaints received from any of the residents over the years but it was stated that the residents had no information regarding the complaints policy. The residence has some community meetings where the views of the residents are welcomed and there is access to an advocacy service.

RECORDS

There was no policy available regarding the residents access to their files. On inspection the files contained the residents' names and ID numbers. They were legible and reasonably tidy. There is no signature bank available. All entries were signed and dated but the professional titles were not used. There were no progress reports from other health professionals and in some cases there were treatment plans, which were quite dated. The consultant reviews the residents every six months and the physical needs are addressed by GPs, who keep their own set of notes. Nursing files were neat and tidy but contained old care plans with progress notes. The medication system is the same as in other residences in the HSE Southern Area. There is a self-medication programme, which is divided into three stages. Medication sheets are in a reasonable condition. Most of them are recently rewritten although some of them date back a number of years.

ENVIRONMENT

There was a regular maintenance programme in place but distance to the residence is a problem for the HSE maintenance staff. Generally, hygiene was good and the décor was reasonable. The toilets and bathrooms needed attention and modernising. The unit appeared to be comfortable and the non-smoking lounge was extremely well furnished and very homely. The smoking lounge needed a more powerful extractor fan.

There was little privacy in the shared bedrooms. They were small rooms and it was questionable whether they were of adequate size for two people sharing. The residence needs to be extended to ensure that each resident has a single room. The residence needed a lift to ensure that people who had any physical disabilities could access the residence. There was reasonable storage space for the residents' property. The residence had four double bedrooms and the rest were single. There was a smoking lounge and a non-smoking lounge, kitchen, two toilets with no disabled access, one bathroom, two shower rooms, a clinic room and an office.

STAFF TRAINING

There is some training available for nursing staff but the distance of the residence from the training locations is problematic. Releasing staff for training is also an issue. Staff reported that they are often notified of training events after the events have happened. While the unit has a computer, there is no Internet access and this has been requested by staff.

KILLARDEN HOUSE, TRALEE

Date of inspection: 29th June 2005

Number of beds: 20

DESCRIPTION

Killarden House was opened in 1995. It is a two-storey building that was formerly a convent. It is located on the edge of Tralee town and has twenty residents. The house also serves as a day centre for the sector. There are up to twenty day attendees. The original profile of the residents was an older group, who were originally patients in St. Finan's Hospital. This is slowly changing and there are now some younger residents. The house is also home to Wells the dog and two budgies.

REFERRAL

All referrals to the residence are through a named consultant psychiatrist for the Tralee sector.

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PROCESS OF ADMISSION

There is no written admission policy. All admissions are cleared by the named consultant psychiatrist. The main focus is on continuing care for the elderly group and rehabilitation for the younger residents. The case files transfer from the acute unit. The senior registrar visits the residence weekly and reviews residents. All residents are registered with a local GP.

CARE PLAN

There are no multidisciplinary care plans in operation.

NURSING PROCESS

There is a nursing model in place but there is no key nurse system.

REHABILITATION TEAM

An occupational therapist attends two days a week and facilitates a group programme in the day centre. The social worker has an office in the building. The NCHD visits one day a week. Residents see their consultant psychiatrist by attending outpatients or on request. All are registered with the local GP and access this service independently if able. There are two nursing staff on day duty and two rostered at night. There are two domestic staff available during the day. The day centre has a visiting drama teacher, gardener and art teacher. A member of the nursing staff runs the day centre.

INVOLVEMENT IN REHABILITATION PROGRAMMES

Residents can attend the day centre programme on site. Many are elderly and prefer to remain in the house and garden and this is facilitated.

UNIT MANAGEMENT

The residence has had a lodger from the acute unit on rare occasions. The residence is also used as a day centre and an office base for social work. There is

continuity of nursing staff, who are centrally rostered from St. Finan's Hospital. There were two discharges in the last year, one to a nursing home and one back to St. Finan's Hospital. Maintenance requests are sent to the main hospital and this process is reported as slow.

HOUSE RULES

There are no house rules. The residents are free to come and go but do not have keys or opportunity to lock the bathroom or bedroom doors. The bedrooms are open at all times. The residents are encouraged to let staff know if they are leaving the building. The main meals come from Kerry General Hospital and a cook-chill system is used. There are up to forty people per day for lunch. There is a small domestic kitchen, which residents can and do access to make drinks or simple meals. There are no set bedtimes.

There is a financial protocol in place. Residents all have bank accounts. Relevant allowances are paid directly into the accounts. Nursing staff collect money for some residents who physically are unable or are not competent to use bank cards. All bank cards are held by staff. Those independent in money management must request the card. Residents buy their own clothes and there is an informal rota for using the utility room. The residents are well known in the community and access the local services. A community link bus stops outside the residence and takes people to town.

SERVICE USER INVOLVEMENT

Residents are given oral information on therapies. There is no formal rota for community meetings in the residence. Complaints are dealt with at a local level.

RECORDS

There are separate medical and nursing notes. All entries are signed and dated. There is inconsistent use of the patient identifier and there is no signature bank. There is an annual review of residents' mental states by the NCHD. The physical reviews are performed by the GP and are not recorded in these

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notes. There is an occupational therapy sheet in the relevant files. Medication is dispensed through a pouch system. However, no residents are self-medicating. The medication sheets are not regularly rewritten. Nursing staff use initials only to sign that medication has been dispensed.

ENVIRONMENT

This old two-storey building was unsuitable for elderly residents in rehabilitation. There were seventeen single rooms and one dormitory containing three rooms. There was very poor natural light in the bedrooms and the windows had small openings, resulting in poor natural ventilation. The shower was inadequate, offered no privacy and was unsuitable for assisted showering. The stairs was difficult to manage and there was no internal lift. There was a homely atmosphere in the house with pets, flowers and garden tunnel adding to the friendly open atmosphere. One man was painting his own room on the day of inspection. All rooms had personal affects in place and there was an internal smoking room. There was a staff rota for mandatory training courses.

TEACH AN CHÚRAM, RATHMORE, CO. KERRY

Date of inspection: 29th June 2005
Number of beds: 12 integrated,
 4 male 8 female

DESCRIPTION

Teach an Chúram is a residence with 24-hour nursing staff supervision on its own grounds on the edge of Rathmore village. It opened in 1997 as a two-storey house with eight residents. In 2001 a 4-bed ground floor extension was added. The age range of patients is between 40 and 76 years.

REFERRAL

All referrals to the residence have come from the East Kerry sector consultant psychiatrist.

PROCESS OF ADMISSION

All 12 beds in the residence are filled on a permanent basis and there are no respite facilities. The last admission took place approximately two and a half years ago and there seems to be little likelihood of any of the current residents being discharged to lower support accommodation.

CARE PLAN

There was no care planning system in place. New issues were addressed when they arose. The nursing staff have met with the Practice Development team to discuss the possible introduction of a care planning system. It has since been reported that a care planning system based on the Orem King model is now in place.

NURSING PROCESS

There is no formal model of nursing in use and no key worker system. According to staff, the nurses respond to the day-to-day needs of the residents.

REHABILITATION TEAM

There is no rehabilitation team in the Kerry Mental Health Service. Residents would appear to have little or no access to social work or occupational therapy services unless they happen to be admitted to the acute unit. There is no psychologist in the catchment service. Residents are seen by the sector psychiatrist in the residence if necessary and are reviewed every six months. They are registered with a local GP.

INVOLVEMENT IN REHABILITATION PROGRAMMES

About half the residents attend the nearby day centre, which provides a variety of activities, including gardening, massage, art and some work assembling window parts. The money earned from this work is pooled and spent on outings for the residents. Some relaxation classes are held in the residence. The day centre has links with FÁS and the VEC – three of the residents undertook a 12-month course involving life skills and computer training.

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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 are two nurses on duty at all times. The shifts are 0800h to 2000h and 2000h to 0800h. The majority of nurses work two days on and two days off. Staff are rostered for night duty on rotation. One of the staff accompanies residents to the day centre and remains with them from 1000h to 1200h and from 1400h to 1600h. This level of staffing seems to be excessive, particularly at night, and the shift system currently in use does not seem to provide continuity of staffing for residents. There are also two household staff on duty each day, one from 0800h until 1400h and one from 0800h to 1730h. One of the household staff cooks the meals and the other provides cleaning and laundry services. Staff do not wear uniforms and do not wear name badges. There is no waiting list for the residence.

ETHOS

The ethos of the unit is to provide a homely atmosphere for residents. It was reported that policies and procedures available in the residence are specific to the high support hostels.

HOUSE RULES

The rules of the residence are designed by the staff. Residents are called between 0830h and 0900h for breakfast, except at weekends, and meals and snacks are provided at set times during the day. Visiting times are flexible but there are no facilities for visitors to stay the night. 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 in order to attend church or visit the shop, both of which are nearby. Two of the residents are allowed go to Killarney unsupervised. The smoking room in the house is sometimes kept locked during the day and residents encouraged to go outside to smoke. Residents are not involved in the shopping for, or preparation of meals and the menu is decided by household staff. Only one of the residents does their own laundry. Three of the residents manage their own money. Staff manage the

money for the other nine. All have independent accounts. A certain number of staff are authorised agents regarding social welfare. Two of the residents can purchase their own clothes independently. All of the others are accompanied by staff.

SERVICE USER INVOLVEMENT

There is no formal measurement of residents' or their families' satisfaction with the service. Staff have informal talks with residents about outings and holidays. There is no written information on therapies or treatment. There is a notice regarding the right to complain. No advocate visits the residence.

RECORDS

The residents' charts were neat and manageable. They contain dated and signed progress reports from nursing staff. They do not contain any care plans or discharge plans. Residents do not write in their files nor do they access them. There is no policy of encouraging those who can to self-medicate. All medication is kept in individual lockers and residents come to the nursing office to receive their medication. Prescription and administration sheets were signed, dated and legible although some of the signatures were not identifiable and no signature bank is available.

ENVIRONMENT

The residence was pleasant and homely and the décor of the building was generally of a high standard. The exception was the smoking room, which was small, poorly ventilated and badly discoloured. There were four single bedrooms with en-suite facilities on the ground floor. Upstairs, there were four double bedrooms. They were pleasantly decorated and all residents had personal belongings in their rooms and adequate storage space. All of the bedrooms had TVs. There was no fire escape upstairs. The lounge, dining room and kitchen were all of adequate space and nicely decorated. The location of a toilet in an upstairs bathroom seemed to constitute a safety risk. There was a laundry room outside which could be accessed by residents. The nursing office

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was large with adequate storage space. There was access to a garden area.

STAFF TRAINING

Staff have received training in cardio-pulmonary resuscitation, lifting and handling, health and safety, and control and restraint. Student nurses undertake placements at the residence.

WRITERS GROVE, LISTOWEL

Date of inspection: 29th June 2005

Number of beds: 14

DESCRIPTION OF RESIDENCE

Writers Grove is a residence with 24-hour nursing staff supervision located in the grounds of Listowel District Hospital on the edge of Listowel town. The residence is a new building, which was opened in 2002 and has fourteen beds. The HSE Southern Area transferred the site to the Kerry Mental Health Association. The residents are an older group with an average age of 68 years.

REFERRAL

All new referrals come through the consultant psychiatrist. All the current residents were former patients in St. Finan's Hospital.

PROCESS OF ADMISSION

There is no written admission policy for the residence. The majority of residents are in continuing care. There is one respite bed, which is accessed through the consultant psychiatrist. There have been two new admissions since opening. The clinical notes follow the residents to the residence.

CARE PLAN

There is no multidisciplinary care planning. In the current year, there was one discharge of a younger

resident to an independent living setting. It is estimated that one or two other residents could move on to lower levels of support. There is no low support residence in the sector. All residents are registered with the local GP and attend for physical review on a yearly basis or when necessary. The residence staff also communicate with the National Learning Network in Listowel regarding the needs of residents.

NURSING PROCESS

Writers Grove is a pilot site for a nurse care planning system. This is based on the Tidal model and also contains a risk assessment. There are five parts to the model: past history, occupational/social, mental state, life skills and risk. There is a key nurse system in place.

REHABILITATION TEAM

There is no dedicated rehabilitation team in the catchment. The sector consultant reviews the residents annually and visits the residence fortnightly. There are two nurses on day duty and two at night. One housekeeping staff member supports the team.

INVOLVEMENT IN REHABILITATION PROGRAMMES

The residents are encouraged to complete household tasks, tend to the garden plot or look after the fish tank and recycling project. This is seen by staff as appropriate for the residents. Individual goals are set for each resident.

UNIT MANAGEMENT

The unit is self-staffing, which ensures continuity of staff. Specific policies and procedures are being developed for the residence. There is no annual report. Residents are encouraged to make personal choices. However this is difficult for many who had spent long periods of time in St. Finan's Hospital.

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HOUSE RULES

House rules are written and are designed by staff in conjunction with residents. Residents do not have a front door key and the door is open. The doors of the bathrooms and bedrooms can be locked. Residents let staff know if they are leaving the residence. The meals are prepared in the district hospital and delivered to the residence. There is limited choice although special diets are accommodated. Breakfast is prepared on site. Residents do not have free access to the kitchen.

There are four double rooms and six single rooms. Some residents have purchased their own furniture and TV sets. There are no set bedtimes. If residents wish to sleep in at the weekends they miss breakfast. Only the belongings of the person in the respite bed are recorded. Residents receive daily and weekly money allowances. There is one resident who is independent in money management. All banking cards are held by staff. The residence had a recent financial audit by the HSE Southern Area. Residents shop for clothes with the assistant of their key nurse. They are encouraged to take laundry to the utility room where household staff launder the clothes. The local town centre is within walking distance. Many use the local betting shops and church on a daily basis. One resident has a radio link to the parish church. A number of residents went on holiday recently and stayed in a hotel. The residence has access to a minibus purchased by the Kerry Mental Health Association and shared with the sector day hospital. All residents are registered to vote and exercise the right. A number of residents ask for information on treatment although the majority do not do so. Complaints were dealt with, if possible, at local level. There is a twice-yearly community meeting.

RECORDS

The files reviewed were in order and contained medical treatment plans. The nursing notes were updated monthly with care plan reviews three-monthly. There is no signature bank in place for all staff. The medication is administered in a pouch system. No residents are self-medicating. The card index system is signed by initials only. The respite file contains only nursing notes. There are no medical notes on site for this person.

ENVIRONMENT

This was a bright, well-maintained building. It had two wings with access to internal courtyards. There was a garden opposite the building. Although a new building, there were a number of structural problems. The shower wet floor area had insufficient slope gradient and no shower guard for staff assisting residents to wash. There was no sluice room for the management of incontinent residents. There was no sink in the clinical room. There was a lack of additional locked press cupboards for medications. Monies were received from the National Lottery and local business to plant the courtyard areas.

All residents spoken to were happy with the care they receive. Overall this is a pleasant homely residence. Residents are encouraged and many have personalised their own rooms. There is adequate personal space indoors and outdoors. The staff on duty on the day of inspection are to be commended for their level of interest and enthusiasm for their individual residents.

STAFF TRAINING

Staff are involved in the Essence of Care programme and student education. They attend mandatory courses on a rota basis.

DEPARTMENT OF PSYCHIATRY, BANTRY GENERAL HOSPITAL

ACUTE ADMISSION UNIT

Date of inspection: 22nd June 2005

Number of beds: 18 integrated

DESCRIPTION

The acute admission unit is situated in a separate building on the grounds of Bantry General Hospital. It consists of three floors: the lower ground floor is an occupational therapy unit, the ground floor contains a reception area, offices and the dining room and the first floor is the main ward area with bedrooms and lounge areas.

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REFERRAL TO UNIT

The majority of referrals are from GPs or through outpatient clinics. Most self-referrals are referred to their GP for initial assessment, except in emergency situations.

PROCESS OF ADMISSION TO THE UNIT

There is an admission policy available on the unit. There have been no admissions of children under 16 years of age for a number of years. People with moderate intellectual disability are admitted to the unit if they have had a history of previous contact with the mental health service. Patients are admitted for alcohol detoxification if they have not consumed alcohol for two days prior to admission. There are occasional admissions for social reasons rather than mental health problems. Patients presenting for admission undergo a joint assessment by nursing staff and the NCHDs. All admissions are discussed with the consultant psychiatrist. The staff liaise with the referring GP. All admissions are seen within 24 hours by the consultant psychiatrist. Patients are not nursed routinely in bedclothes following admission. If necessary, patients sleep in the observation dormitory in the initial period following admission. A key worker is allocated to the patient on admission.

CARE PLAN

There is a comprehensive formal multidisciplinary care plan for each patient on the unit. Patients are involved in developing their own care plans and each review of their care plan. There is a weekly multidisciplinary care planning meeting and the patient meets with their consultant psychiatrist and key professionals involved in their care plan once a week. Where appropriate, carers and family members are involved in the patient's care plan. There is a documented discharge plan, which is decided by the patient and the multidisciplinary team. Part of the discharge plan involves communication with the patients' GPs, family members (where appropriate), the community service and community mental health nurse.

NURSING PROCESS

The nursing model used on the unit is the Tidal model of nursing. Staff stated that this is appropriate to the needs of the patient group. There is also a risk assessment in use (Sainsbury Risk Assessment). There are two levels of observation: general observation and one-to-one (special) observation. There are also two observation dormitories. A key worker system is in operation.

ACCESS TO THERAPY

Patients have access to social workers and occupational therapists as part of the multidisciplinary team. The social workers and occupational therapists also attend the ward on a number of occasions during the weeks to meet staff and patients. There is no psychologist in the service, although there is a vacant post. Cognitive behavioural therapy is available, provided by trained nursing staff. The consultant psychiatrist visits the unit three or four days a week and the NCHD reviews patients daily. All medical and surgical emergencies are seen in the general hospital immediately. Non-emergency consultations may take a number of days. The mental health service provides a same-day consultancy service to Bantry General Hospital.

ACCESS TO THERAPEUTIC PROGRAMMES

There is an occupational therapy department in the acute unit. Patients are referred by the multidisciplinary team for specific therapeutic interventions as part of their care plan. All referrals are assessed by the occupational therapist. Group therapy such as relaxation, exercise, art therapy, gardening and daily living skills is available, as well as individual therapy.

ECT

ECT is not carried out on the unit, although there are some minimal facilities available.

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SECLUSION

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

CLINICAL RISK MANAGEMENT

All policies are available on the unit. The Sainsbury Risk Assessment is routinely used in the unit and a copy is kept in the patient clinical file. All staff have recently completed training in control and restraint techniques, de-escalation techniques and cardio-pulmonary resuscitation. There is a system of reporting serious incidents. Feedback is through the Director of Nursing. The staff were unaware of results of any yearly audit of serious incidents. Debriefing and review of serious incidents does occur.

UNIT MANAGEMENT

Patients are not "slept out" in other units to free beds for new admissions. However, beds of patients on leave from the unit are occasionally used by new admissions. Patients requiring intensive care are transferred to the Carraig Mór unit. Since the previous inspection, a new procedure has been developed to facilitate direct admissions to Carraig Mór involving assessment and/or liaison by the patient's GP and consultant psychiatrist. This has greatly improved the service for the patient and dispenses with unnecessary journeys and potentially distressing time for the patient in the acute unit in Bantry General Hospital. The door of the unit is usually open but may be locked if necessary. There is a locked door policy and a record is kept of the times that the door is locked and this is reviewed every two to three hours. CCTV is used for external security only. There are four nursing staff on duty in the daytime with two household staff and three nursing staff on duty at night. Secretarial support is available. A phlebotomy service is provided by the general hospital.

SERVICE USER INVOLVEMENT

Information leaflets about the mental health service and other social and health services are available for patients. There is a complaints procedure and

information about the procedure is available. There are user meetings with patients in the occupational therapy department. There is regular access to advocates from the Irish Advocacy Network. A number of patients were interviewed. All were aware of their care plans and stated that they had been involved in formulating them. One patient complained about the shortage of space on the unit.

RECORDS

The patients' files were neat and manageable. The front covers contained patients' names, addresses, numbers, dates of birth and sections for noting any drug sensitivity. An admission data sheet, which contained further details including status and relevant contact names and numbers, was attached to the inside of the cover. The files contained separate sections for the various disciplines (medical, occupational therapy, social work, psychology and community mental health nurses) to record their entries. Miscellaneous material was contained in a section in the back of the chart. The discussion of the patient's case and decisions at the ward round were clearly noted in the charts. Entries were all dated and signed but not all signatures were legible nor were the titles always used. In the case of a patient transferred from Carraig Mór, there was no clear admission assessment or physical assessment by a doctor. Nursing notes were comprehensive, containing patient assessment, risk management sheet, care plan, day and night reports and a discharge plan. A card index system was used for medication. The prescription and administration sheets were generally in good order, the generic names of drugs were not always used and the discontinuation of medication was not always signed and dated.

ENVIRONMENT

The unit is situated on three floors but has no lift connecting the floors. There was a pleasant reception area on the ground floor. The stair lift was not working at the time of the inspection. This resulted in patients with mobility problems having no access to the dining room, the occupational therapy department or an outside area. The dining room was downstairs and was adequate. Overall the unit was

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cramped, especially on the first floor, which was a long corridor with rooms opening from each side. There was a separate smoking area and a pleasantly decorated lounge area with plenty of books and newspapers as well as TV. There were three single bedrooms. The other bedrooms contained between two and four beds each. The nursing station was small and looked onto two observation dormitories. The occupational therapy department consisted of a large activity room, incorporating a cooking area and laundry facilities for assessment and training, and two small rooms, one of which was used for relaxation.

WEST CORK

ARDRÉALT HOUSE, BANTRY, CO. CORK

Date of inspection: 23rd June 2005

Number of beds: 10 integrated

DESCRIPTION

Ardréalt Residence is a 24-hour staffed residence in the grounds of Bantry General Hospital. It opened in 2002 and is a purpose-built unit. At present, the first floor is used by nurse therapists for counselling services and the residents are located on the ground floor. There is one respite bed. The age range of residents is between 30 and 82 years.

REFERRAL

Residents are referred from the community, from other residences and from the admission unit. All referrals to the residence are discussed at the sector team meeting.

PROCESS OF ADMISSION

Each resident has a mental health assessment following referral. The nursing staff in the residence also assess the patient prior to admission. There is also a risk assessment carried out before the resident is admitted. Residents are admitted to take part in a rehabilitation programme with the aim of moving to less supported accommodation if possible. The

residence does not provide an alternative to admission to the acute unit. The residence also provides a respite programme for periods of up to three weeks and there have been 23 respite admissions over the past year.

CARE PLAN

Each resident has an individual multidisciplinary care plan and this is reviewed monthly. Resident and their families, where possible, are actively involved in the care plans.

NURSING PROCESS

The nursing process is based on an assessment using the social functioning questionnaire, which is used in developing the patient's care plan. There is one nursing staff member on duty during the day and one nurse on duty at night. The nursing staff attend the weekly sector team meetings.

REHABILITATION TEAM

There is no rehabilitation team in the West Cork Mental Health Service. Residents have access to the sector social worker and occupational therapist. There is no psychologist in the catchment service. Residents are seen by the sector psychiatrist at outpatient clinics and in the residence, if necessary. The residents are able to choose their own GP.

INVOLVEMENT IN REHABILITATION PROGRAMMES

Residents are able to attend Dromleigh day service, which is located next door to the residence, as part of their care plan. Currently, three residents are attending the centre. The day centre is small but provides a number of activities for day attendees. Another client attends the intellectual disability service during the day. A number of residents are now able to self-medicate following a self-medication programme.

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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 are household staff present for six hours a day. There is no waiting list for the residence. There is one person awaiting a placement in a lower support accommodation.

ETHOS

The ethos of the unit is to promote independence and to move residents to lower support accommodation if possible. All policies and procedures are available in the residence.

HOUSE RULES

There are no formal house rules. Alcohol is not allowed in the residence. Visiting times are open. The front door is always open and the residents do not have their own keys. Residents are free to go in and out as they please. The staff and the residents cook all meals in the residence, but the residents are not involved in shopping for food. The residents have free access to the kitchen. There are no set bedtimes and breakfast is between 0830h and 0900h. Residents keep their own belongings in their bedrooms. As far as possible, the residents manage their own finances and all have their own bank accounts. Their allowances are paid directly into their individual accounts. Residents purchase their own clothes but may be accompanied by staff while doing so and they use all community facilities in the town such as shops, cafes and pubs. Residents have been involved in various festivals and plays in the community. All facilities are within walking distance.

SERVICE USER INVOLVEMENT

There is no formal measurement of residents' or their families' satisfaction with the service. There are residents meetings and informal talks with staff about the running of the residence, outings and holidays.

RECORDS

The file of each resident contained a personal details sheet which had a photo of the resident and which included a list of contacts, a section on drug sensitivity and allergies and details of the resident's ability to self-medicate. They also contained social functioning and Problems/Deficits questionnaires, an occupational therapy programme, care plan sheets, a depot recording sheet if applicable and separate sections for entries from medical, nursing and other personnel. The chart of the most recently admitted resident contained an up-to-date rehabilitation programme, a plan of activities based on the individual resident's needs and co-signed by the resident and the occupational therapist. There was evidence that the care plans were reviewed on a monthly basis or more often if necessary. The nursing notes contained summaries after every five days. All entries were signed and dated. Some signatures were not legible and titles of staff were often omitted. The prescription and administration sheets were generally in good order. The medication charts contained self-medication sheets where applicable.

ENVIRONMENT

The residence was very pleasant and homely. At the time of inspection, the residence had access only to the ground floor. However there was ample living space. The lounge area was spacious and comfortable and there was a separate smoking room. There was a large dining room and kitchen. There were four double bedrooms, all en-suite, and two single rooms. They were pleasantly decorated and all residents had personal belongings in their rooms and adequate storage space. One of the single bedrooms was for the respite service. There was a laundry room and residents were encouraged to do their own laundry. The nursing office was large with adequate storage space. There was access to a garden area.

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ELMWOOD RESIDENCE, SKIBBEREEN

Date of inspection: 22nd June 2005

Number of beds: 11 male

DESCRIPTION

Elmwood is a residence with 24-hour nursing staff supervision located approximately one mile outside the town of Skibbereen. It opened in 1992 and has eleven beds. The age range of patients is between 60 and 84 years. The residence is rented by the HSE Southern Area from the Cork Mental Health Association. There are very few admissions or discharges to the residence and the residents are all elderly. Some have mobility problems, while others have early dementia. Most require high levels of supervision.

REFERRAL

The majority of the residents were referred from St. Stephen's Hospital or were transferred when Our Lady's Hospital, Cork, closed. Some residents have been transferred from Perrott House, which is another 24-hour staffed residence in Skibbereen.

PROCESS OF ADMISSION

All admissions come through the sector team. There was no specific admission policy available in the residence. There are no respite admissions and the residence is not used as an alternative to admission to the acute unit. All residents received a psychiatric assessment either prior to admission or after admission to the residence.

CARE PLAN

There is a care plan in operation, which is appropriate to the residents' needs. The residents are not actively involved in their care plan. All residents are assessed using the social functioning questionnaire and are re-assessed every 12 months.

NURSING PROCESS

There is one nurse on duty during the day and one at night. Most clients require support from staff in daily living skills such as making beds and personal hygiene.

REHABILITATION TEAM

There is no rehabilitation team in the West Cork Mental Health Service. Each resident is reviewed every six months by the sector consultant psychiatrist. Residents have access to a social worker and occupational therapist if required. There is one GP for all the residents in the residence although it was stated that a resident may choose a different GP if he wishes. There are occasional multidisciplinary meetings in the residence.

INVOLVEMENT IN REHABILITATION PROGRAMMES

Residents do not attend any day services off site. There is no active programme with the aim of moving residents to less supported accommodation. The residents have access to newspapers, TV and radio. Art therapy was available until recently. Residents go on accompanied walks and occasional outings. A gardener is provided by the VEC two days a week and residents are involved in an excellent garden project on site. There is an exercise group and massage therapy is available. No resident is currently self-medicating. No residents have been discharged to lower level of support during the last year. Any discharges have been to residences with a higher level of nursing staff.

Staff are involved in a review of all residences and residents in Skibbereen with a view to increasing the rehabilitation input into the residences.

UNIT MANAGEMENT

The door of the residence is open. There are no temporary transfers to or from other units. The availability of maintenance was reported as being good. There are household staff available to the residence.

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ETHOS

All policies and procedures were available in the residence. The emphasis in the residence was that of providing a caring and homely environment for the residents.

HOUSE RULES

The residents are not actively involved in devising house rules. Smoking has been limited by staff to five cigarettes a day. Bedtime is flexible and visiting time is open. The front door is only locked at night and residents do not possess a front door key. One client is allowed to leave the residence unsupervised. Meals are cooked by the staff with the help of residents. The residents are not involved in planning or shopping for meals and do not have free access to the kitchen for snacks or drinks. Residents are in possession of their own belongings and buy their own clothes, accompanied by staff.

Residents are requested to sign their social welfare books in the residence. Allowances are collected by staff and paid into two overall accounts, one for rent for the residence and the other for all the residents. The residents do not have their own bank accounts. Most of them are unaware of the amount of their money in the overall account. This is further complicated by the fact that the rent is paid back to the residents each month into the overall account as a result of the recent decision by the Department of Health and Children not to charge persons in long-stay care in HSE institutions and to refund all previous charges. A detailed statement of each resident's money in the overall account is kept by staff but is not automatically made available to residents. Due to the distance from the town most residents do not regularly take part in community activities. They do not regularly go to the shops, local pubs or other facilities.

SERVICE USER INVOLVEMENT

There are regular residents meetings, in which the general running of the residence is discussed. There is a complaints procedure but no resident had made any complaint. There is no formal mechanism for measuring residents and families' level of satisfaction.

RECORDS

The residents' clinical files were up to date. Regular outpatient reviews were documented. The medication sheets were up to date. The nursing files were legible and up to date.

ENVIRONMENT

The residence was very homely and pleasantly decorated. It was situated in an extensive garden. There was a large lounge with TV, newspapers and books. There was a large kitchen and dining room. The bedrooms were single and double bedrooms, which were nicely decorated. Each resident had adequate storage space and each had their own personal possessions.

PERROTT HOUSE, SKIBBEREEN

Date of inspection: 22nd June 2005

Number of beds: 28 integrated, 11 male, 13 female

DESCRIPTION

Perrott House is a residence with 24-hour nursing staff supervision in a large building owned by the HSE that was formerly the acute unit for the West Cork area. A separate part of the building is used as a sector headquarters for the Skibbereen sector of the West Cork Mental Health Service. The residence opened in 1996 and is approximately one and a half miles from Skibbereen town.

REFERRAL

Most of the current residents are in the residence since its opening and came here following the closure of Our Lady's Hospital in Cork. Ten of the residents are from the Clonakilty/Skibbereen sector and 14 from the Bantry sector.

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PROCESS OF ADMISSION

All admissions are through the sector team. There is no admission policy specific to the residence. There are no respite facilities and the residence is not used as an alternative to an admission to the acute unit. All patients received a comprehensive assessment prior to their placement in the residence and an assessment after admission.

CARE PLAN

A nursing care plan is in place for each of the residents. This focuses mainly on physical needs. The views of the resident are sought when the care plan is being updated.

NURSING PROCESS

No specific nursing model is in use. There is no formal risk assessment but problems and difficulties of each individual resident are noted in the care plan.

REHABILITATION TEAM

There is no rehabilitation team in this service. Nursing staff refer to other disciplines, e.g. social work, on particular issues as they arise. Residents are seen by the sector psychiatrist in the residence if necessary. NCHDs visit the residence four days a week and a GP visits twice weekly. A chiropodist visits monthly and as required. A public health nurse visits according to need.

During the early months of 2005, a working group was established to review the mental health residential services in Skibbereen and to make recommendations on the appropriate care for existing clients and on future need and demand for residential service. A social functioning questionnaire and the FACE Health and Social Assessment were used to assess the dependency levels and needs of each of the residents. A comprehensive report was prepared which suggested that, of the 43 people current in the Skibbereen mental health residential services, only nine of the residents require medium to high support or nursing home accommodation.

INVOLVEMENT IN REHABILITATION PROGRAMMES

Five of the residents leave the residence each day to attend the National Learning Network and are involved in programmes such as computer training and life skills and literacy skills development. The remainder of the residents are involved in programmes that are run in the residence – relaxation, music, keep fit, motor skills exercises, basic food hygiene, kitchen skills, and reminiscence therapy. A gardening programme takes place in the residence grounds, which are quite extensive.

UNIT MANAGEMENT

There are no temporary transfers to or from the residence due to bed shortages in other units. When the majority of residents were on holiday, some residents stayed at a nearby low support residence for the duration. The residence is not self-staffed. There are three nurses (occasionally four) on duty from 0800h to 2000h and two nurses from 2000h to 0800h. While there is some continuity of staffing, nursing staff are centrally rostered which results in a turnover of staff in the residence. There is also 1 unqualified occupational therapist who works in the residence from 0900h to 1700h, Monday to Friday and one occupational therapy assistant who works five mornings per week. There are two cooks who job-share, one home help who works ten hours per week, one attendant and one kitchen staff.

ETHOS

The ethos of the unit is to provide a homely atmosphere for residents, to look after their individual needs and to assist the residents to develop their skills and acquire new skills. All policies and procedures available in the residence are common to the service.

According to the working group on the Skibbereen mental health residential services, front line staff in Perrott House felt that their service provided a caring environment and a high quality of accommodation, it did not adequately meet the increasing physical need of some of the present resident group and also did not fully meet the rehabilitation philosophy of empowerment with the promotion of independence.

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HOUSE RULES

The rules of the residence are designed by the staff, mainly concerning health and safety issues. Residents are called for breakfast which is at 0800h. Visiting times are flexible and the majority of residents have family or friends visiting. Visitors are asked to try to leave the residence by 2030h, when the door is locked. 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 do not have free access to the kitchen but there is a plentiful supply of snacks/drinks. Smoking is only permitted in a designated smoking room or outside the house. Residents are involved in the planning of meals, which are then prepared by staff. The laundry for the residence is done externally. Only one of the residents manages their own money. One is a Ward of Court. The money for the remainder of the residents is collected by a member of staff. Each resident has a bank account. Two nurses have to sign money in and out. The books are audited twice yearly.

SERVICE USER INVOLVEMENT

There are informal talks with staff about outings and holidays. Residents are given verbal explanations on medications and side-effects. There are no notices regarding the right to complain and no suggestion box. There is no formal means of getting feedback from the residents about the quality of care they receive. No advocate visits the residence.

RECORDS

There are separate nursing and medical files. Most of the nursing files contain a photo of the resident inside the front page. The care plans are updated every four weeks. The files were up to date and contained regular reviews and progress notes. All entries were signed and dated. Medication sheets were also up to date.

ENVIRONMENT

The residence is a large institutional building, which makes it difficult to provide a homely atmosphere. The majority of residents sleep in large 8-bed

dormitories, which are unsuitable for long-stay accommodation in the community. Each resident has a wardrobe and locker and a curtain around their bed. The dining room and lounge areas are large enough to accommodate all residents at once. An extension to the building, which was built with the assistance of a voluntary organisation, is bright and modern. Outside this area, a large patio had tables and chairs where residents were able to enjoy meals and relaxation in the good weather. The grounds around the building are extensive and a large area is given over to a gardening project.

STAFF TRAINING

Staff in the residence have received training in crisis prevention intervention, first aid, lifting and handling, fire safety, and health and safety. Some distance learning materials are also available.

ST. FINBARR'S HOSPITAL

ST. CATHERINE'S WARD

Date of inspection: 5th July 2005

Number of beds: 8 male, 16 female

DESCRIPTION

St. Catherine's is an integrated 24-bed ward in St. Finbarr's Hospital. The function of the ward is continuing care of patients with some emphasis on rehabilitation. The ward is open and there were no detained patients at the time of inspection.

REFERRAL

The main source of referral is the Ground Floor Acute Unit, Cork University Hospital and also the high support hostel at Glanmalure. The referral process is contact is made with the consultant who carries out an assessment.

PROCESS OF ADMISSION

There are no people under the age of 16 admitted to this unit. There are people with a moderate

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intellectual disability and clinical responsibility rests with the consultant psychiatrist. People are not admitted for detoxification but are admitted in social crisis. A consultant psychiatrist carries out an assessment prior to transfer to this unit so there is prior knowledge of the patient. There is a GP attached to this unit who is responsible for maintaining the physical well-being of the patients. The collateral history is regularly updated. The decision to admit is made by a consultant psychiatrist.

The GP is notified of the admission as well as family members. The admission process is to assess the patient for a few days and then draw up a programme. The consultant psychiatrist reviews the patient within the first week and the initial treatment plan is documented in the case notes. It is very rare that a patient is nursed in night clothes due to a risk of absconding; if this was the case it is authorised by the doctor or the patient is transferred to the acute unit. There is a key worker system in operation.

CARE PLAN

Care planning is carried out by the nursing staff. The staff use the Tidal model which has been adapted. This is a needs-identified system which leads to goals and objectives being identified for the patient. The key worker system in the unit is divided into three sections of 8 patients. The staff are allocated to each of these groups. There is a rigid shift system where staff work opposite each other and this does not promote continuity of care. Care plans are reviewed on a regular basis and are documented in the patient's notes.

Once the patient is identified as suitable for transfer to a hostel, a gradual process is put in place to prepare them for eventual discharge.

NURSING PROCESS

As already stated, the nursing model in use is the Tidal model which is appropriate to the needs of the patient group and is implemented by the nursing staff. It contains a minimal risk assessment. The staff on this unit all wear uniform.

ACCESS TO THERAPY

Access to a psychologist is by request only. Four people over the age of 65 years need to be assessed by a psychologist to determine a future placement. There was formerly an occupational therapist on this unit but the post is now vacant. There is access to a social worker on referral but it was noted that every client has had an accommodation needs assessment carried out. Unfortunately there are minimal facilities in the community for these patients. There is one consultant psychiatrist who has responsibility for the unit and a weekly review of the patient group is carried out. As stated earlier, the GP carries out the physical examinations. The unit also has access to a physiotherapist, dietician and phlebotomist. It was reported that an experienced NCHD visits the unit daily.

ACCESS TO THERAPEUTIC PROGRAMMES

There is an evidence-based group therapy programme on the unit. This is facilitated by a nurse therapist and the groups range from solution to wellness, cooking, social skills, current affairs and gardening.

CLINICAL RISK MANAGEMENT

There is a clinical risk management policy in place that is implemented by the South Lee Mental Health Service. There is also a health and safety statement. There is no alarm system in operation although the exit doors are alarmed. There are policies on alcohol and illegal drugs, patients missing from the unit, the management of violent episodes, searching patients' belongings, and searching patients' room or bed area.

Rapid tranquillisation is prescribed on the patients' chart if appropriate but it is rarely needed. If a patient refuses their medication this is documented and discussed with the consultant and it may be decided to move the patient to the acute unit and to review their Voluntary status. There is no mechanical or physical restraint used on this unit although staff are trained in control and restraint techniques. The staff are also trained in cardio-pulmonary resuscitation and have some training in the

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medication used in mental health. Other training was available in particular some workshops on the Tidal model and mandatory training.

Serious untoward incidents are reported on appropriate forms which are forwarded to the Assistant Director of Nursing. It was also reported that any episodes of verbal abuse are recorded on appropriate forms and sent to occupational health who then contact the member of staff concerned.

UNIT MANAGEMENT

Patients on this unit are not transferred temporarily to facilitate other patients. However it was reported that if the ward has a vacant bed it receives patients from the Ground Floor Acute Unit due to bed shortages. There are monthly ward management meetings to discuss potential admissions. The patients on this unit have free access off the ward and they inform the nursing staff where they are going and what time they will be back. The unit is only locked at night for safety reasons. The only other use on the ward is a clozapine clinic that runs weekly.

The unit is staffed through a central rostering system. There are very few regular staff on the unit and the key worker system does not provide the continuity of care required. There is an information booklet for the induction of new staff but staff rotate frequently to this unit. There is currently no ward clerk although it is reported that it would be beneficial to have one.

There are currently four people reported ready for transfer to a high support hostel but there are no places available. Maintenance is carried out by the hospital maintenance staff and switchboard is provided by the hospital. There is open visiting to this unit. There are fixed meal times and there is availability of snacks and drinks in between meals.

SERVICE USER INVOLVEMENT

There is information available on the medication used in mental health for the patient group. There is availability of information on their rights. There is a HSE policy on complaints and this is clearly advertised within the unit. There are regular community

meetings held on a monthly basis and minutes are kept. The minutes were made available on this inspection. Carers and families' opinions are sought verbally when they visit the unit or are telephoned. There is also access to advocacy.

RECORDS

The medical files contain patient's name and ID number on the pages that were legible. A number of the pages were loose in the files. Entries have the name of the person but not the title and they are signed and dated. There are no progress reports from other health professionals as they do not have input into the units. There is a treatment plan and also evidence of regular reviews. The frequency of consultant psychiatrist review is weekly and the NCHD is available daily if necessary.

The nursing files are legible and tidy. They contain the Tidal model assessment and a brief risk profile and a social functioning questionnaire. There were regular progress reports and also regular reviews of the care plans.

The medication sheets are all regularly signed, dated and are legible. The majority of sheets were recently rewritten, but a number have medication prescribed in 2004 and these need to be rewritten.

ENVIRONMENT

This is a 24-bed unit situated on two floors. The main living area was upstairs and the sleeping area was downstairs. It was situated in a large hospital close to the city centre. There was an ongoing maintenance programme and there was disabled access with a lift in place. The lighting, ventilation and décor were good. There were appropriate noise levels and the corridors were a good width. There were numerous information boards containing relevant and up-to-date information. There was no dedicated visitors area but the CNM2 stated they had defined minor refurbishment work to provide a visitors' room within the unit. This had been costed and a decision was awaited as to whether this would be facilitated.

There was access to a beautifully maintained garden which was an excellent facility. The patients on this

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ward helped maintain the garden. The bedroom areas were all dormitories and were situated downstairs. The dormitories were either six-, four- or three-bed. They all had curtains around the beds and individual wardrobe space. It should be noted that the wardrobes were of excellent standard. The dormitories were immaculately clean and tidy and there was also a lounge area where the patients could watch TV in the night time and there was a smoking area as well.

The toilets and bathrooms were of reasonable decorative order. There was free access to the toilets and shower rooms but the bathroom was kept locked. They were gender specific and there were overriding locks on the doors. There was one disused bathroom currently on the unit and it was hoped that this could have been converted into a utility room where the patients could have washed their clothes. There is currently a utility room but it is upstairs in the unit away from the main bedroom areas.

The dining area was able to accommodate all residents at one sitting and was integrated in the unit. The lounge area was open plan and had comfortable seating, with access to newspapers, TV and radio. The CNM2 identified an area within this lounge which should be partitioned off to provide a more homely sitting room. The CNM2 pointed out they accessed numerous sources of funding i.e. lottery funds, to try and carry out the minor works within the unit.

The nurses' station was situated at the end of a corridor and it was quite isolated from the main body of the ward. It was confidential and there was space for report writing and, although down the end of the corridor, was accessible to the patient group.

Some of the patients on this unit were in receipt of benefits. The general office managed the patients' money although they all had savings accounts or bank accounts. Some money was kept on the unit for use by the patients and there was a social fund contribution of €2 per week.

ST. MONICA'S WARD

Date of inspection: 5th July 2005

Number of beds: 15

DESCRIPTION

St. Monica's is a 15-bed long-stay ward on the grounds of St. Finbarr's Hospital. It has 15 patients, six aged 65 years and over. The unit is open.

REFERRAL

Referrals are received from all sectors. They are processed through one named consultant psychiatrist who has responsibility for the ward. Some residents are transfers from St. Catherine's Ward and some are more physically dependent.

PROCESS OF ADMISSION

The consultant psychiatrist makes the decision to transfer patients to this ward. The case notes are transferred from the appropriate ward. There is a GP linked to the ward. The GP visits each Tuesday afternoon or as needed. Six-monthly physical reviews are completed although not documented in the case file on site. The consultant psychiatrist visits weekly, or as needed, if a patient requires immediate review.

CARE PLAN

There is no multidisciplinary team input into the ward and therefore no multidisciplinary care planning.

NURSING PROCESS

The nursing staff are using an adapted version of the Tidal model and social functioning questionnaire. There is a risk assessment component. No key nurse system is in place. There are two levels of observation, general nursing observation and special nursing.

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ACCESS TO THERAPY

There is no dedicated social work, occupational therapy or clinical psychology time for this ward. The consultant psychiatrist is available on site twice weekly and the GP visits once weekly.

ACCESS TO THERAPEUTIC PROGRAMMES

The patients attend a number of programmes off site. Three patients attend the National Learning Network. Two patients attend the day hospital in Ravenscourt. Other patients attend an activation programme on St. Catherine's Ward. This is also referred to as occupational therapy, although there is no occupational therapist present.

ECT

ECT is not available on the ward and nobody is in receipt of this treatment.

SECLUSION

Seclusion is not used on the unit.

CLINICAL RISK MANAGEMENT

There are risk assessments completed although medical staff do not use a formal instrument. There were three deaths in 2004 from natural causes. Day space has been increased with a reduction in bed numbers. It was reported that this has created a safer environment for the more physically dependent patients.

UNIT MANAGEMENT

The ward is open during the day and locked at 2200h. Nursing staff are consistently rostered to this ward. The female nursing staff and household staff wear uniforms. Bloods are taken by the phlebotomy service on site or by the designated clozapine nurse. There is no waiting list. Up to three patients could move on to a high support hostel. Maintenance

requests are the responsibility of the mental health services but this is a slow process. Meal times are at set intervals and the meals are cooked on site in the hospital.

SERVICE USER INVOLVEMENT

There are no set community meetings and it was reported that patients do not request information. The Irish Advocacy Network does not visit the ward. There is regular communication with families of patients who spend time at home.

RECORDS

The medical records reviewed did not show evidence of six-monthly mental state reviews. The signatures were legible and there was no patient identifier on each page. The nursing files showed no evidence of timely reviews. There are no signature banks for any staff. The drugs medication list in files reviewed had not been rewritten in years.

STAFF TRAINING

Staff can access training in cardio-pulmonary resuscitation and control and restraint. These courses are not mandatory and there is no training in rehabilitation.

ENVIRONMENT

This was a two-storey building located in St. Finbarr's Hospital. There were no single bedrooms. One triple bedroom was located downstairs off the dining room. All other bedrooms were located upstairs. The building was very difficult for older patients. The toilets and shower area downstairs was inaccessible for more infirm patients to access unaided. Overall the building was dark, in need of refurbishment and not suitable for residents in the long term. Patients can access a pleasant side garden.

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CORK UNIVERSITY HOSPITAL

ACUTE PSYCHIATRY UNIT

Date of inspection: 4th July 2005

Number of beds: 46

DESCRIPTION

This is a 46-bed (23 male and 23 female) acute unit that serves a population of 167,000 and has six general adult teams and one team for old age psychiatry. It is located in a two-storey building linked to Cork University Hospital. The unit also serves as a clozapine clinic one day a week.

REFERRAL

All direct referrals must be accompanied with a letter from the GP. They are assessed on the ward by the NCHD. A decision to admit is taken by a consultant psychiatrist. In A&E, patients are assessed by the liaison team and a decision to admit is made on clinical need. The unit operates off a waiting list. The waiting list is formally reviewed three times a week; informally this is reviewed daily based on clinical need.

PROCESS OF ADMISSION

The admission policy has recently been redrafted and is awaiting signing off by the management team. People under 16 and those with a moderate intellectual disability are rarely admitted. They are admitted under the care of the sector team. Admission purely for detoxification or social reasons has been reduced since the introduction of the liaison team. Patients are reviewed by the consultant psychiatrist between 12 and 24 hours post admission. The integrated care plan is commenced immediately and a key nurse is assigned, based on sector teams. On admission the stated levels of nursing observation are either special (one-to-one nursing) if required or general observation. The emphasis is on a key nurse system moving away from recording timed observation. This is in line with the Refocusing Acute Psychiatry Project.

CARE PLAN

There are no multidisciplinary care plans in place. There has been an attempt to introduce a multidisciplinary pre-ward round review as part of the Refocusing Acute Psychiatry Project. This is not consistent throughout the six sector teams. On discharge a three-way duplicate note is completed. One is filed, one is given to the patient and one is sent to the patient's GP.

NURSING PROCESS

Nurse plans changed to the Tidal model fifteen months ago. This is currently under review. Staff wear ID badges. There is only one identified level of observation and that is one-to-one nursing.

ACCESS TO THERAPY

The six sector teams are underdeveloped. There are three social workers, one psychologist and no occupational therapist. There are regular reviews by consultant psychiatrists. Patients have full access to medical and surgical services, X-ray and phlebotomy within the hospital.

ACCESS TO THERAPEUTIC PROGRAMMES

There is a general activation programme facilitated by a nurse and a woodwork instructor. There is no occupational therapist in post and there is a full-time art therapist on the ward.

ECT

The ECT suite was situated off the main corridor of the ward. The majority of patients who had ECT were in-patients and therefore use their own bed area as a waiting area, although there was a waiting area next to the ECT suite. All the appropriate equipment was present in the preparation room, along with the appropriate anaesthetic equipment, and the recovery room was one of the dormitory areas. There would have been adequate space for three people to receive ECT at one time.

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SECLUSION

There is no seclusion room, however there are transfers to Carraig Mór (a low secure unit). In 2004 there were 50 transfers and to date in 2005 from January to July there has already been 39 transfers to Carraig Mór.

CLINICAL RISK MANAGEMENT

All staff carry alarms with the response coming internally and from the hospital security. Tests for drug and alcohol misuse are used regularly on the ward, for which consent is obtained. A number of elderly patients are restrained in bed by cot sides. There are HSE Area-wide policies and procedures in place for dealing with serious incidents. All serious incidents are reviewed by the Clinical Director and the Director of Nursing and adverse incidents are discussed at the six-weekly clinical audit meetings.

UNIT MANAGEMENT

The ward is open. Patients are actively transferred to secure unit in Carraig Mór. There is a CCTV camera at the side entrance which is linked to one of the staff offices. Nursing staff are centrally rostered. Staff are encouraged to wear day clothes, however the female staff continue to wear uniforms. The ward is also used as a clozapine clinic on a weekly basis. This increases the number of people on the ward and is unsuitable for the acute unit. There is good access to support services. Meals are at regular intervals and the food was reported by patients and staff as being of a very high standard.

SERVICE USER INVOLVEMENT

There is access to written information on rights and medication. A weekly community meeting is held each Saturday and minutes are kept. Complaints are dealt with at a local level if possible. There is a complaints officer in place and an advocate visits the ward on a weekly basis.

RECORDS

The patient's name and ID number is on all pages using a sticker system. The notes were legible. Unfortunately there were a number of loose sheets within the files. There was a signature bank available. Entries had the full names and titles of personnel, signed and dated. There did not appear to be any progress reports from allied health professionals although there was a section for the art therapist. There was a treatment plan which contained dated and signed progress reports. The consultant psychiatrist reviews patients several times a week and the NCHD reviews on a daily basis. There are separate nursing files which are legible, tidy with entries signed and dated. Drug prescription cards are signed, dated and legible. Generic names are used and discontinuations of medications are signed and dated.

The chart of a patient who received ECT was complete. There was evidence of consent being obtained. A chart of an Involuntary patient who had only recently been admitted was inspected: the nursing notes and the medical notes available were accurate and stated reasons for the Temporary status, although the full medical file was not available.

ENVIRONMENT

This is a 46-bed acute admission ward situated in a general hospital. There is a regular maintenance programme. There is some disabled access although the male dormitories were upstairs and there was no lift. Lighting and ventilation appeared to be good and the décor was of a good standard. The corridors were extremely busy and narrow. There was the appearance of a thoroughfare through this ward. It was also noted on the day of inspection that the clozapine clinic was happening in the female dormitory area with members of the public accessing this area. This is totally unacceptable and a new venue must be found for this clozapine clinic. Noise levels were acceptable on the unit and there were suitable and numerous information boards with relevant and up to date information, including a progress report on the Refocusing Acute Psychiatry Project. There were codes of conduct evident on the wards and there was some clerical support. There was a dedicated visitors' area which also doubled up

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as a waiting room. There was access to a nice garden which was also the smoking area.

There was a dedicated reception area that had reception staff with minimal barriers and an information board. There were brochures available and there was some seating near the reception area. There were two interview offices and one of these doubled as the assessment area for referrals. This was in the main body of the ward and was unsuitable for this purpose. The bedroom area was situated on two floors. The female area was downstairs and there was a mixture of 6-bed or 4-bed dormitories. There were some single rooms available within both sleeping areas. There were curtains around the beds in the dormitories and there was wardrobe space.

Toilets and bathrooms were of a reasonable standard. Bathrooms were kept locked but the showers were open. They were gender specific and there were overriding locks on the doors.

The dining area was a large area situated in the main corridor of the ward and there was space for all residents at one sitting. This could be quite problematic with over 40 people accessing this facility. The staff requested that the patients be served at their tables to avoid long periods of queuing. There was an exercise and activity area which was separate from the main body of the ward and there were a number of activities carried out in this area, including art therapy, woodwork and table tennis.

The lounge area was a large area just off the main corridor of the ward which again had the appearance of a waiting room. The furniture was arranged into two defined areas, one of which had access to TV, the other had no access.

As stated earlier, there were two interview rooms which were always in demand. They were soundproof and had large observation panels within the doors. The nurses' stations were situated in the main corridors of the ward with one for the male staff and one for female staff. They seemed to have enough space for report writing and were accessible. There was telephone and IT input to these offices. The clinical room was not inspected as it was being used as a clozapine clinic.

SOUTH LEE

GLENMALURE HOUSE

Date of inspection: 5th July 2005

Number of beds: 18

DESCRIPTION

Glenmalure House residence is located 1.5 miles from the centre of Cork city and is close to local amenities. It is owned by the HSE and opened in 1990. There are seven male and twelve female residents. A number of residents were admitted to the residence when Our Lady's Psychiatric Hospital closed. Residents are admitted from St. Catherine's Ward and through the six sector teams.

REFERRAL

The sources of referral are identified above and the process is from one consultant psychiatrist to another. The mechanism is as follows: a consultant psychiatrist and nursing staff from the residence assess the individual referral. It was reported that at the beginning of the assessment the patient needs to sign up to the programme that is run within the residence and they must be willing to participate in a rehabilitation programme. If accepted, the resident has a gradual process of visits to the residence to become familiar with the residence.

PROCESS OF ADMISSION

There is an admission policy within the residence, the only exclusion criterion is a recent history of violence. If somebody is not prepared to participate in the rehabilitation programme they are given the opportunity to take part in activities within the residence. The residence is not used as an alternative to acute admission, respite care, detoxification or for social crisis.

The assessment on admission is linked to the Tidal model and the social functioning questionnaire. The assessment is predominantly nurse led and a physical examination is carried out by the GP. A collateral history is taken and is updated on a regular basis. The person deciding to make the admission is usually

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the consultant in conjunction with the nursing staff. The Tidal model ensures that the resident is involved in their treatment plan and the care plans are reviewed on a monthly basis. Good active liaison is encouraged with family members; they visit the residence on a regular basis and a number of the residents go home on leave. The consultant psychiatrist carries out a monthly review but also sees people in out-patient clinics. An initial treatment plan is documented in the nursing notes. The medical notes are not kept in the residence and this is a policy of the residence. There is a key worker system and the two permanent staff are allocated to the residents.

CARE PLAN

As already stated, the care plans are linked to the Tidal model. This ensures that needs are identified and appropriate goals and objectives are set. Care plans are reviewed on a monthly basis. The NCHD signs the care plans and each intervention written in the progress notes is shared to the patient to ensure that they agree with what has been written and the patient also signs this intervention.

Once it is determined that somebody is ready for discharge from the residence there is a gradual use of leave for a planned period of time. There are limited facilities for discharging people. While there are no medium or low support residences in the area, there is one house with no staff so the resident must be independent to access this facility. Two people were discharged last year and it is estimated that there are currently three people appropriate for moving to a low level of support.

REHABILITATION TEAM

There is no regular access to a psychologist, occupational therapist or social worker. One consultant has responsibility for the residence and carries out monthly reviews but also sees residents in out-patient clinics. All residents are registered with a local GP.

INVOLVEMENT IN REHABILITATION PROGRAMMES

There is evidence of needs-based individual programmes and residents are involved in these programmes to promote their move to a lower level of support and independent living. Residents attend services off site and go unaccompanied.

CLINICAL RISK MANAGEMENT

There is a policy on risk management available. There is no alarm system as it was not deemed necessary. There are policies on the use of alcohol and illegal drugs within the residence and on people missing from the residence. The residents are allowed to go to the pub for a drink but may not bring alcohol into the residence. There is no policy on searching residents but this is not done on a voluntary basis and the staff could only recall this happening when some money went missing. Any serious incidents are reported on the appropriate forms and these are sent to the Assistant Director of Nursing.

UNIT MANAGEMENT

There are no temporary or long-term transfers from this residence due to shortages of beds within the service. The residence is not used for any other purpose. All nursing staff are qualified. There are two nursing staff on duty 24 hours a day. The residence has regular staff but on the day of inspection there were temporary staff covering due to situations beyond the control of the nursing management. There was one household staff and one cook on duty during the day.

The ethos of the residence is to promote independent living and to move people on to living in lower support accommodation in the community. There is a formal policy for inducting residents and staff. There are appropriate policies and procedures present within the residence. Maintenance is carried out by the HSE.

HOUSE RULES

There are house rules in place and these are designed by staff in conjunction with the residents. There are

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reviews of house rules when appropriate. Visiting times to the residence are flexible and people do not have overnight guests. Residents do not have a front door key. It was pointed out that the door is open during the day. Residents can lock the bathroom doors but they cannot lock their bedroom doors. Residents are allowed to leave the residence unsupervised and they give a verbal message to staff as to where they are going and what time they are expected back. Residents are not required to be out during the day although they are all involved in programmes that involved community access.

Meals are prepared within the residence and there is a cook dedicated to this process. Residents help with preparing meals and are involved in menu planning and shopping. They have free access to the kitchen and make their own drinks and snacks.

Residents are not required to go to bed at any particular time or to get up at any particular time in the morning although it was pointed out that they all have programmes and some go to work or college and are therefore requested by staff to get up at certain times. The majority of the rooms are shared but the residents may choose with whom they want to share.

All residents have their own bank accounts and currently do not pay any money towards their keep within the residence. The majority of residents manage their own finances although some prefer to give their money to staff for safekeeping. It is reported that all residents are in receipt of benefits they are entitled to and they are required to pay €7 per week into a social fund that provides for outings, Christmas parties and other items. Residents can purchase their own furniture but the HSE provide all the furniture and fittings for the residence. The residents also buy their own clothes from local shops.

There is an active programme within the unit that involves a number of community projects. Some of the residents are attending college courses and go to Killeen House. A number of residents work either with voluntary agencies providing home help or working in charity shops. The local facilities are within walking distance and they are encouraged to use public transport.

SERVICE USER INVOLVEMENT

The residents are actively involved in their own care. Once the resident signs the care plan, they sign the interventions that are written about them in the progress notes. Residents spoke very positively about the residence and said that they felt very involved in their care. They did not feel pressured or rushed to move on to more independent living but that being in the residence was preparing them to make a move.

RECORDS

As stated earlier the medical files are stored in the hospital and are used during out-patient appointments, hence they were not inspected. The nursing files are accessible to the residents. They contain name and ID on all pages and are legible, tidy and contain up-to-date care plans.

There is a self-medication policy in place within the residence. There are three levels, ranging from staff giving medication to people managing their own medication. There is a thorough policy in place and procedures that link to Abbey Health Care who provide the medication in blister-packs.

ENVIRONMENT

There is a regular ongoing maintenance programme in place provided by the HSE. The hygiene within the unit was good. This was an old Victorian house and the décor was of a very good standard. There was some maintenance required at the back of the house. The environment was very homely and there were some pleasant furniture and fittings within the house. The bedrooms were mostly shared and it was noted that the single rooms were very small. There was adequate storage for residents' belongings. It was noted that there were two flights of stairs within the residence and no lift so as residents' physical state deteriorates the residence may not be an appropriate placement.

The residence consisted of two lounges which were nicely furnished. There was also a dining room, a range of shared and single bedrooms, a kitchen, a smoking area outside and an office.

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STAFF TRAINING

Staff have access to the same training that is available to the staff that are based in the hospitals and in the community.

NORTH LEE

CARRAIG MÓR, SHANKIEL

Date of inspection: 5th July 2005

Number of beds: 40

DESCRIPTION

This is a two-storey stand alone unit. The first floor is used for the care of longer term patients who are deemed to require long-stay facilities of low secure level and have been transferred from Our Lady's Hospital. The ground floor functions as a more secure intensive care unit with some long stay patients.

This inspection will focus on the downstairs unit. There were 20 places downstairs, 10 male and 9 female with one vacancy on the day of inspection. It was a locked unit. Of the patients, 10 were Temporary and 9 were Voluntary. As part of the development of the new forensic team, a registrar had been assigned to the downstairs unit as of the 1st July, 2005.

REFERRAL

There were 192 admissions to the downstairs unit in 2004. They came from four acute units. However some patients from West Cork were directly admitted. This has been a source of conflict for some time. Ideally they should be assessed in an acute unit prior to transfer to Carraig Mór, however the geography poses difficulties. In the other areas all patients are assessed in the acute unit first. One of the difficulties in West Cork has been the small size of the in-patient unit and the limited number of staff available at any particular time to escort patients to Cork. The staff in Carraig Mór do not carry out an assessment prior to admission. There was no clear unit-specific admission policy for this unit. The Carraig Mór information leaflet states under admission policy that the centre provides a more

secure environment with a higher nurse-to-patient ratio for patients who because of their mental condition cannot be managed safely in an open admission unit. Patients are referred from the acute admission units attached to any of the catchment areas in County Cork.

PROCESS OF ADMISSION

The unit sees itself as providing a psychiatric intensive care service to the region. Patients under the age of sixteen are not admitted nor are patients with dual diagnosis nor are there admissions for detoxification. Patients with deliberate self-harm in the context of social stressors may be admitted. For all areas except West Cork a full psychiatric assessment and treatment plan is completed in the relevant acute unit prior to the patient's admission to Carraig Mór. The decision on the need for admission to Carraig Mór is taken by the patient's consultant psychiatrist. The psychiatric assessment on admission is completed by the registrar for the unit during normal working hours and by North Lee on-call NCHD out of hours.

There is no formal policy on patients being nursed in night clothes. There is no formal policy on observation levels on admission and it is assumed that all patients are in a high observation area, the dormitory in these units being directly beside the nurses' station. Although there is no night clothes policy, patients who are considered to be a danger to themselves may be nursed in refractory clothing.

CARE PLAN

There was no multidisciplinary assessment or care planning although this is planned with the setting up of the new forensic service.

NURSING PROCESS

The nursing model used is the Roper Logan Tierney model upstairs and a mixture of the Roper Logan Tierney and Tidal model in the downstairs unit. The Tidal model is being piloted in a number of sites in the region and there are plans to introduce it into Carraig Mór. The current nursing model does not incorporate a risk assessment and there are plans to

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have a risk assessment in the new model when it is introduced. A primary nurse is appointed to each admission and this is fairly consistent. One-to-one nursing is very rarely used even though patients who are suicidal may be admitted. Nursing staff wear name badges. Probationary staff are sometimes taken out of the unit to do special one-to-one nursing elsewhere and this is an issue of contention.

ACCESS TO THERAPY

There are no counsellors available in the unit although they attend the day hospitals. A priest comes into the unit and says Mass and runs a social group. There is now one full-time consultant psychiatrist for the unit who plans to also work in the community. The consultant psychiatrist visits the downstairs unit on a daily basis. Access to regional medical and surgical consultations is good and staff are facilitated in the general hospital if they are accompanying patients for outpatient appointments. There is good access to laboratory and X-ray results.

There were no occupational therapists assigned to the unit. However one occupational therapist came in on Tuesday afternoons for two hours from the Mercy Hospital. A social worker in the Mercy Hospital was contacted, if necessary, whereas patients from the South Lee area obtained social work from the Ground Floor Unit social work service if required. There were no psychologists available to the unit. If a patient required a psychologist he or she was referred to the North Lee/South Lee psychology service.

ACCESS TO THERAPEUTIC PROGRAMMES

At the time of inspection there was a 7-week programme being conducted by Music Network Ireland and there were plans to conduct an evaluation on this after the programme finished. The art programme is run by nursing staff.

Nursing staff run a programme from 0900h to 1700h five days a week. This programme includes art, relaxation, stress management, music and computer training. Patients go swimming and on bus outings.

ECT

Patients very rarely receive ECT. If they require it, they travel to the Mercy Hospital in North Lee or the Cork University Hospital in South Lee where they receive treatment.

SECLUSION

Despite being a secure unit there is no seclusion room in the unit. There are plans to develop a safe room as it is recognised that there are some patients who require access to a safe room when they are disturbed. There are no plans to introduce seclusion into the service.

CLINICAL RISK MANAGEMENT

The nursing care plan does not contain a formal risk assessment. There is no policy on risk management available as yet. There is a pinpoint alarm system and HSE Area policies on alcohol and illegal drugs, patients absconding and giving medication without consent. There are guidelines available for the management of violent episodes. There is no policy on rapid tranquillisation. Patients' belongings are rarely searched but there was a policy on searching the patient's room or the bed area. No mechanical restraint was used in this service. Physical restraint was used from time to time.

The staff have all been trained in control and restraint techniques and verbal de-escalation was emphasised. If physical restraint was used it was documented in an incident report. The duty doctor is also called and the Assistant Director of Nursing notified. There is a policy on boundaries. Overhead night-dresses made from refractory cloth are used and lighters are not allowed on the unit. Staff have access to the one-year National University of Ireland Certificate Programme on Forensic Nursing in a Secure Environment and they have access to control and restraint techniques, breakaway techniques and cardio-pulmonary resuscitation training. They regularly have study days and updates provided by An Bord Altranais. Clinical risk assessment is not yet adequately developed. It is planned to introduce this and to document it in patients' charts. Serious clinical incidents are reported on the incident form and

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audited in the standard way. Debriefing is available following serious incidents. The employment assistant programme using the Mitchell model of debriefing is also available and staff are quite satisfied with this.

UNIT MANAGEMENT

Attempts are made to have two beds available at all times for acute emergency admissions. There is no waiting list. Sometimes a patient may be swapped out to another service to facilitate an admission. Rarely patients go upstairs to a bed that is kept there.

Sometimes patients take their own discharge. Patients are usually seen by their own team before they are discharged from the service. There are no long-term transfers to other units.

The staff felt that there were currently five males awaiting placement elsewhere, however all of these required locked accommodation. One of these patients has a head injury.

The doors are always locked and patients in the downstairs unit are rarely allowed off the ward. There is CCTV in operation outside, in the visitors room and in the smoking room. The ward is not used for any other purposes.

There were five male nursing staff and four female nursing staff on day duty with three male and three female staff on duty at night time. There were two additional nursing officers on duty during the day and one nursing officer at night covering the two storeys. There were two nursing staff in therapy working from Monday to Friday 0800h to 1700h.

In addition there were two domestic staff upstairs and two domestic staff downstairs each day with none at night time and one cleaner based in the front area that contained the staff dining room for the building. A security company supplied a service in the daytime from 0700h to 2100h.

There are cooking staff with a chef for the patients and a chef for the staff. Induction of staff needs to be formalised. It is usually informal and addresses the alarms and issues of confidentiality. The females wear a uniform and the males have a dress code.

There is no ward clerk available for the unit and bloods are taken by the NCHD.

There is a need for emergency access to maintenance and ongoing maintenance work. The switchboard is in the Regional Hospital and there are some direct lines. Meals are at 0800h, 1230h and 1720h. There are regular snack and drinks breaks. Visiting times are flexible.

SERVICE USER INVOLVEMENT

Information on treatment and therapies are available in the art room and there is information on patients' rights on the notice board. Information leaflets will need to be updated when the new service is developed. Information on complaints, suggestions and comments is available in the information leaflet. Once a month there are unit community meetings within the service and an advocate attends the unit once a week.

RECORDS

With regard to records, they were legible, tidy and there was a signature bank available. All entries were signed and dated. There were no progress reports from allied health professionals. The nursing care plan was the only treatment plan. There was a regular review by the consultant psychiatrist and by the NCHD for the unit. In the nursing files, the patient's name and ID number were on all pages. They were legible and tidy and all entries were signed and dated. A signature bank was available. The entries did not have a full name and title for the personnel involved. With regard to medication, prescription and administration records, the generic names were not used but they were legible.

ENVIRONMENT

In general the environment was quite satisfactory. The rooms were clean and reasonably decorated. However there was little evidence of private belongings. There was a 6-bed dormitory beside the nursing station on the female side along with three female single rooms and a safe room that could also be used as a bedroom. On the male side there was a 7-bed dormitory and three male single rooms. There was an en-suite in the female dormitory. There was

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none in the male dormitory. There were three toilets on the male side and one male shower room. On the female side, there was one female shower room and one female bathroom. There was one male sitting-room, a smoking room and two day rooms. The dining room was integrated and all food was cooked on site. The therapy area contained an art room, a computer room, a pleasant visitors' room. Access to the ward was through double doors manned by security. There was a burns emergency kit inside the front door. The clinical room had a defibrillation kit.

OWENACURRA UNIT

Date of inspection: 6th July 2005

Number of beds: 32 integrated, 17 male, 15 female

DESCRIPTION

Owenacurra unit provides a mixed package of care: continuing care for an increasingly ageing population, rehabilitation for younger patients and also respite care. It is an open unit and all patients are Voluntary status.

REFERRAL

All patients are referred by GPs, from the clinics, or from St. Michael's Unit. All patients are assessed either in the clinics or St. Michael's Unit prior to admission. The consultant psychiatrist for Owenacurra makes the decision to admit. Patients may be admitted directly from home for respite or rehabilitation or they may be transferred from St. Michael's Hospital in the post-acute phase of their illness if they come from the catchment area (Youghal, Midleton and Cobh). Since the inspection, a 12-place day care facility has opened in Cobh. Although the staff are clear about the admission policy there is no written policy for this unit outlining the procedure for referral and assessment both during working hours and out of hours.

PROCESS OF ADMISSION

As stated there is no clear admission policy. This service is developing its role and function and plans

to review all of its policies when the full multidisciplinary team has been appointed. Children under 16 years are not admitted to this unit nor are patients with moderate intellectual disability and psychiatric illness. There are no admissions for detoxification. There are two respite beds that may be used for admission for patients in the context of a social crisis. All patients must be seen in St. Michael's prior to admission. As of the 1st July this year a NCHD has been assigned to Owenacurra and the day centre that also covers Youghal and Midleton. When patients are admitted to this unit they are physically examined by the NCHD for the unit or by the duty doctor. GPs attend to the routine physical needs of patients on these units. There has been a dispute regarding performance of the six-monthly physical examinations which in the past were attended to by the GPs in the area. It has now been agreed as of 1st July that the NCHD for the unit will perform the six-monthly physicals and document them in the charts. The consultant psychiatrist makes the decision to admit. The GPs are very involved in the referral process and are kept informed as to what is happening with them. The Tidal model that is being used in St. Michael's is to be introduced into Owenacurra. Staff stated that the family are very involved in the admission process. As patients are all Voluntary they are nursed in their day clothes. It is an open unit so there is no policy on admission levels. There are no special nurses appointed in Owenacurra. The patients are assigned a key nurse following admission by the nurse in charge.

CARE PLAN

There is no formal multidisciplinary care planning process for in-patients. At the team meetings patients are referred to the sector occupational therapist, psychologist and social worker when deemed appropriate. The social worker has an office on the ward and is readily available. The psychologist has been recently appointed but is required to attend to the learning disability service as well.

NURSING PROCESS

The nursing model used is the Roper Logan Tierney one although there are plans to introduce the Tidal model. It does not contain a risk assessment. Staff wear name badges and there is a dress code.

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ACCESS TO THERAPY

Six of the patients attend the day centre, which is directly behind the unit, on a number of days each week. There is very limited psychology input. Patients can receive occupational therapy only if they are able to attend the day centre. The staff describe very good access to the social worker recently. Counsellors are available in the day centre. A consultant psychiatrist attends every two weeks and more frequently when required, and directly following admissions. The NCHD has a meeting every week. Patients are referred by the GP if medical and surgical investigations or consultations are required and they are satisfied with the service. Results of investigations come back to Owenacurra and the staff send photocopies of these to the GP. A number of patients in the unit are attended to by their GP from home which means a number of different GPs attend the unit.

ACCESS TO THERAPEUTIC PROGRAMMES

Nursing staff on the unit do newspaper reading, the Sonas programme and art with the patients in an activity room on the unit. More active patients attend the day centre. Some patients attend the community school and a VEC programme with links to FÁS. Mass is available on the unit every Wednesday.

ECT / SECLUSION

There is no ECT or seclusion used on the unit.

CLINICAL RISK MANAGEMENT

As stated, all the patients are Voluntary. The HSE Southern Area policies on absent patients and managing violent episodes apply and are available on the unit. Patients' belongings are occasionally searched. There is no written policy in relation to this available. Physical restraint is not used on this unit. With regard to mechanical restraint, at the time of inspection there were no Buxton chairs or cot sides in use and staff are advised that even if they were used for safety reasons this should be documented.

Staff described good access to training in control and restraint, de-escalation, breakaway techniques, cardio-pulmonary resuscitation and medication. Serious incidents are reported using the standard incident form which is forwarded to the Director of Nursing in St. Michael's and the ACNOs and audited in the usual way. Debriefing is available through the HSE Southern Area.

UNIT MANAGEMENT

The unit has an open door policy, being locked only at night, and the staff in this unit also supervise eight residents in community-based houses. Patients may be asked to stay at home an extra night while on leave to accommodate an admission occasionally. They are never be moved to other wards to facilitate such an admission. Patients if they become acutely ill are transferred to St. Michael's or Carraig Mór and patients who become more physically dependent may be transferred to the community hospital or St. Stephen's Hospital. The nursing staff provide all the activities that are available on the unit and patients have free access off the ward. There is no CCTV in use on the unit. Some outpatients attend the unit on a regular basis for meals and medication. There are four staff on duty in the daytime and three by night. This is a self-staffing unit.

RECORDS

A number of files were perused. The patients' files contain separate entries for medical, occupational therapy and social work professionals. The cover of the chart details the patient's name and date of birth and any drug sensitivity or allergy. Of concern was the fact that the six-monthly physical reviews had not been done for some years. This apparently resulted from the dispute between the GPs in the area and the hospital management and this has recently been addressed. The week prior to the inspection four of the six-monthly physicals had been performed and documented in the case notes. This difficulty will be addressed in future by having an NCHD assigned to the unit who will perform the six-monthly physicals. There were no clear guidelines available to nursing or medical staff on the frequency of entry required. This aspect could be improved.

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ENVIRONMENT

This was generally satisfactory. Since the inspection last year, a new garden area had been developed in the central part of the unit. The ward consisted of a square around a central garden with comfortable seating. The majority of rooms were single rooms. There were also a couple of 2-bed and 3-bed rooms. There was very little communal living space. The communal living space consisted of one smoking room, one non-smoking sitting-room and one occupational therapy room which doubles up as a visitors' room. The clinical room was quite cramped and needed to be improved and there were two offices, one at the central nurses' office and a room beside this where patients could take phone calls or have some privacy. There was a need for soundproofing between these two rooms. The social worker office was based on the unit, as was the laboratory. There was one dining room that could accommodate all patients in one sitting although it was quite small. Food was cooked on the unit. There were two showers, one for disabled and one other; there was one bathroom. This was perceived as being adequate for the number of patients on the unit. There were 17 single rooms, one 2-bed male room and four 3-bed rooms. All the bedrooms with more than one patient had a toilet and wash-hand basin area en-suite.

MERCY HOSPITAL CORK

ST. MICHAEL'S UNIT

Date of inspection: 4th July 2005

Number of beds: 50

DESCRIPTION

St. Michael's ward is located on the first floor. It is a 50-bed unit. Access to the unit is by swipe card or intercom on the ground floor. Internally there is free access via an adjoining corridor to the main hospital building. The unit is divided into two sections an 18-bed acute area and 32-bed sub-acute area.

REFERRAL

The main source of referral is GPs. They also receive referrals from A&E, outpatients and self-referrals. The normal process of referral is a referral letter and the catchment NCHD carries out the initial assessment, or if out of hours the on-call doctor.

PROCESS OF ADMISSION

People under 16 are occasionally admitted to the unit and they are nursed on a one-to-one basis. The catchment consultant maintains clinical responsibility. There are also occasionally people with a moderate intellectual disability admitted and they are also looked after by the catchment consultant. There are a number of admissions for detoxification but these people usually have a risk of self-harm. It is rare that people are admitted for social crisis.

The NCHD carries out the full psychiatric assessment, including a mental state examination, at the point of referral. A physical examination is carried out if a patient was admitted and a collateral history is taken. If the decision to admit is clear-cut the NCHD makes the decision. If there is any doubt, a consultant psychiatrist is contacted. The patients' GP is not routinely informed of a patient's admission. However they are informed if they are involuntarily detained as they are involved in the process. On admission, the patient is involved in their treatment plan, depending on their mental state. All admissions are given an information booklet and are allocated a key worker. The key worker and the NCHD orientate the patient to the unit and discuss the treatment plan. There is communication with the family regarding admission if appropriate. The consultant psychiatrist reviews the patient within the next working day and if they are involuntary, within 12 hours. The initial treatment plan is documented in the medical notes.

There is a policy to place people who may be at risk in their night clothes. The observation levels on the unit are one-to-one or general observation. The key worker is allocated according to consultant team.

CARE PLAN

The unit is one of the pilot areas for the Refocusing Acute Psychiatry Project. Care plans are needs identified and involve appropriate persons to meet

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these needs. Goals and objectives are identified and the key worker is also identified. Due to the nature of the Refocusing Acute Psychiatry Project the patient is involved in the care plan. The discharge plan is decided at the team meeting and is part of the Refocusing Project. The GP, family and community teams are notified of the discharge plan.

NURSING PROCESS

The unit adapted the Tidal model by reducing the holistic assessment from 21 questions to 12. The key worker implements the model and it is appropriate to needs. There is a risk assessment contained within the Tidal model.

ACCESS TO THERAPY

There is access to a psychologist but there are only three psychologists covering five sector teams. There is occupational therapy on site and also within the community. There are also nurse therapists within the acute unit. There are four social workers to five sector teams.

There are five consultant psychiatrists who have beds within the unit and they review the patients at least weekly. There is access to laboratory and X-ray results. Currently there are two people who are diagnosed with anorexia nervosa on the unit so there is access to a dietician.

ACCESS TO THERAPEUTIC PROGRAMMES

There is evidence of needs-based group therapy within the unit and there are a number of groups available ranging from recovery to relaxation, groups on medication, compliance and stress.

ECT

There is an ECT policy and procedure in place and an ECT register. There is documentation on the number of patients who receive ECT and there are appropriate consent forms. There is information available for the patient and there is a nursing

procedure and checklist. Designated ECT nurses are the CNM3 plus the primary nurse and there is also a designated ECT consultant. The ECT suite is on site. There is an appropriate waiting area, preparation room, ECT treatment room and recovery room.

SECLUSION

There is no seclusion within the unit.

CLINICAL RISK MANAGEMENT

It was reported that there is a need to develop a risk management policy. There is a pinpoint alarm system in operation and there is a policy governing this. There is an alcohol and illegal drugs policy as well as a policy for patients absconding. The staff are in receipt of control and restraint technique training for the management of violent episodes although not all staff have been trained yet. The consultant psychiatrist decides which medication is used for the purpose of rapid tranquillisation; there is a policy for the procedure on giving medication without consent and the only time this would be done is with a Temporary patient. It was acknowledged that there is a need to develop a policy on searching patients' belongings and their bed areas.

As stated earlier, staff are in receipt of control and restraint training for physical restraint. It was reported that there is a Buxton chair which is very rarely used within the unit. It is the only form of mechanical restraint. Staff have training in cardio-pulmonary resuscitation although it is noted that some staff need an update. The clinical nurse specialist provides training on medication and there is other mandatory training available.

There is a clinical risk assessment as part of the Tidal model and Refocusing Acute Psychiatry Project.

There are serious incident forms. The forms are regularly audited and information sent back to the unit.

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UNIT MANAGEMENT

It is a rare occasion that a patient is transferred to a hostel due to pressure on acute beds. The main procedure is to use leave beds or to speed up somebody's discharge. With regard to long-term transfers to other units, patients are transferred to Carraig Mór in a crisis situation. There are seven to eight people from the North Lee area who require long-stay beds and who are blocking beds either on the admission unit or in Carraig Mór.

Patients have access within the unit to activities facilitated by the occupational therapist and nurse therapist. Patients have different levels of leave from the unit and this is assessed on a day-to-day basis. The door of the acute area is locked if there is a patient at risk of leaving the unit. The main door to the unit is locked at night and on a rare occasion has been locked in the daytime for short periods. There is now CCTV on the unit due to some problems with visitors bringing in alcohol and drugs. There is CCTV in the two smoking rooms, the end of the main corridor and at the front door. Staff on the unit are from a central roster although there is a core staffing group. The CNM3 is developing an induction booklet for new staff but there is a profile of the unit in place. All staff wear uniform. It was reported that there is no administrative or ward clerk available to the unit. There is an increasing amount of administrative work that the nursing staff are carrying out which detracts from their nursing duties.

There is a waiting list for this unit and there is a weekly meeting on a Monday where all sectors are represented and the waiting list is discussed and prioritised. It was reported that there are currently six patients who are awaiting appropriate discharge placement.

There is a maintenance programme carried out by the Mercy Hospital and this was described as excellent. The switchboard is also via the Mercy Hospital. Visiting times are 1400h to 1600h and 1800h to 2100h. Meals are at set times and within reason there are drinks available between meal times.

SERVICE USER INVOLVEMENT

The unit developed a folder on all medications used in psychiatry and this is available for the patient

group. Information is available through group involvement. All patients receive an information leaflet which advises them of their rights. There is a complaints procedure in place. The HSE have a policy on complaints and have a complaints officer. A community meeting is held weekly and this seeks the views of the patient group; carers and family have the option to share their views on visits or by appointment. There is access to advocacy and there are regular sessions held on the unit.

RECORDS

The charts reviewed, nursing and medical, had a number of positive elements. They were current and up to date. Signature banks for medical and nursing staff were current and available. There is an attempt to introduce multidisciplinary notes. There is evidence of occupational therapy and social work input into the clinical files. As part of the Refocusing Acute Psychiatry Project, a number of pre-multidisciplinary team review sheets were in the charts. This is a welcome step and although not consistent in all sector teams it should be fully implemented and audited to measure its effectiveness. There is no patient identifier on some pages. The drug card index was in order. The use of highlighter pen to note discontinued medication should cease. Medication lists should be rewritten as necessary.

ENVIRONMENT

The acute psychiatric unit was located on the first floor of the Mercy Hospital. Access was through intercom or swipe card on the ground floor. There was a stairs or lift access to the ward area on the first floor. There were a number of offices also located on the ground floor, for nursing staff, social work and clinical psychology. The ward area was a fifty-bed unit. It was divided into 18 acute beds and 32 sub-acute beds. There was an adequate amount of access to showers, toilets and bathing areas. There was a fully assisted Parker bath located in the acute bed area. The unit was bright and well maintained. There was no access to an external garden or courtyard area. There was an internal smoking room with an extractor fan that had restricted opening times. There was a conservatory room overlooking a river and this was bright and spacious. There was a mixture of 6-

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bed areas and double rooms, all of which were en-suite. There was a general recreation room that was open for activation activities facilitated by a therapy nurse. There was an occupational therapy area that consisted of an office, kitchenette and multi-purpose room. There was an ECT suite and recovery room. There was also a visitors' room. There was no seclusion room in this unit.

There was an 18-bed acute area within the main body of the unit. There had disabled access and the lighting and ventilation were good. The décor was of a good standard. There were no corridors within this area. Noise seemed at appropriate levels and there were information boards with detailed and current information available for the patients. As stated earlier, there was a need for clerical support within the acute and sub-acute area of this unit. There was no designated visitors' area. Unfortunately, there was no garden access for this unit as it was in the centre of the city. The reception area was in the main body of the ward.

The bedrooms were split into two 6-bed dormitories, one for men and one for women and one 4-bed dormitory and two single rooms. Privacy was maintained and there were curtains around the beds in the dormitories. Each patient had their own wardrobe space and the décor was of a good standard. The toilets and bathrooms were adequate for the number of patients. There was free access to the facilities and they were gender specific. There were overriding locks on the doors. The dining area could accommodate all patients in one sitting. It was kept locked between meal times due to the potential disruptive nature of some of the patients. It was self-service integrated and the décor was of a good standard. The lounge area was in the main thoroughfare of the ward. It had the appearance of a waiting room area although there were appropriate numbers of chairs and a TV available.

There was also a smoking lounge within this area which had an adequate amount of chairs although the ventilation did not appear to be extracting smoke from the room. There were two interview rooms available on the unit. They appeared to be soundproof and they were just situated off the main body of the unit. There were adequate observation panels in the doors.

The nurses' station was centrally located in the unit. It was open plan so confidentiality was an issue. There seemed to be adequate space for report writing successful to the patient group and there was a phone system. It was reported that they were wired for IT but as yet they were awaiting equipment. The alarm system was a pinpoint system. The clinic room was in the main body of the ward.

STAFF TRAINING

The staff have access to degree courses, higher diploma courses and a forensic course.

GOUGANE BARRA HOUSE

Date of inspection: 5th July 2005

Number of beds: 16

DESCRIPTION

The residence is located on the main road. It is a three-storey building that is owned by the HSE. The Mental Health Association is caretaker of the building. It has a side car park that is accessed by swipe card. Staff visiting the acute unit in Mercy Hospital also uses it. All of the sixteen residents were discharged from Our Lady's Hospital in 1986. The average age of each resident is 60. There are ten male residents and six female residents.

REFERRAL

There are no active referrals. All referrals come through a named consultant.

PROCESS OF ADMISSION

There have been no recent admissions. The consultant psychiatrist visits the residence and there is no key nurse system in place.

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CARE PLAN

There are no multidisciplinary team care plans and no multidisciplinary team input into the residence. There was one death and one discharge last year in 2004. Both places remain vacant. All residents are registered with local GPs and visit as required.

NURSING PROCESS

There is no set model in place. It is currently under review.

REHABILITATION TEAM

There is no dedicated rehabilitation team. There are two staff nurses in the daytime and two staff nurses at night. There is also one attendant during the day who cooks and cleans the residence. A consultant psychiatrist visits weekly.

INVOLVEMENT IN REHABILITATION PROGRAMMES

Five residents attend St. Killeen's industrial therapy on the grounds of Our Lady's Hospital from Monday to Friday. The other residents remain in the house and access community services as appropriate.

UNIT MANAGEMENT

The residence has an ethos of continuing care. There is no annual report compiled and no residence-specific policies. The nursing staff and attendant staff are consistent. The nursing staff are dressed in casual clothes and there is no formal method of measuring residents' levels of satisfaction.

HOUSE RULES

There are unwritten house rules designed by the nursing staff. Residents do not have a front door key and are unable to lock bedrooms or bathroom areas. The meals are prepared on site by one attendant. Residents are not involved in meal planning or preparation. There is a roster for cleaning and laying

tables. There are three single rooms and five double rooms. Residents have remained in the unit since transferring from Our Lady's Hospital. All residents independently manage their own money. Staff do not collect any benefits on behalf of residents. Rent is €52 per week. This is currently not being collected, following a directive from the Department of Health and Children. Residents have received no written information regarding this. Residents can and do access community facilities independently. There is public transport nearby. All food stuffs and household goods are delivered from Our Lady's Hospital. The central heating oil is paid for by Our Lady's Hospital and residents receive a receipt for paying rent.

SERVICE USER INVOLVEMENT

There is no community meeting. Complaints are dealt with locally and are rare. All patients are registered to vote.

RECORDS

The medical records were of a very poor standard. There was no evidence of active reviews. There were gaps of years between written notes. Physical reviews were completed by GPs and are kept in the GP files. The nursing file is currently under review. Notes are only written as required. No residents are self-medicating. Although residents going out are given a daily medication to manage. There are no signature banks available and the medication lists have not been rewritten in the recent past.

ENVIRONMENT

This was a dark three-storey house. All residents must be fully mobile as all bedrooms were located upstairs. It was in urgent need of refurbishment and decoration. There was a pleasant rear garden and there was an internal smoking room.

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NORTH LEE

MILLFIELD HOUSE

Date of inspection: 5th July 2005

Number of beds: 15

DESCRIPTION

Millfield House is a two-storey residence located in an industrial estate. It has a large side and rear garden. The residence opened in 2002 and is home to 15 residents – eight male and seven female. It is located in the North Lee Sector and is the responsibility of a named consultant psychiatrist. The residence also incorporates a day centre, which has six to eight day attendees, and an outpatient clinic is held each Tuesday morning in the building. The average age of residents is 50. The industrial estate site is currently under review and it is likely that it will be bought by a property developer. If this happens the residence will have to be relocated. This may prove an ideal opportunity to move the residence into a more community-based setting.

REFERRAL

All new referrals must come through a named consultant psychiatrist. They are usually seen first of all in a Mercy Hospital acute unit. The majority of patients however have been discharged from Our Lady's Hospital. The consultant psychiatrist makes the decision to admit the person to the residence. They are initially admitted for a one-month trial period. The majority have family involvement and the family are made aware of the transfer. The clinical files come from the Mercy Hospital. There are no multidisciplinary care plans and no multidisciplinary input into the residence. Monthly meetings are held by the consultant psychiatrist, Assistant Director of Nursing, day centre staff and the residence staff regarding residents in the residence and patients attending the day centre. Minutes are kept of these meetings.

NURSING PROCESS

The nursing model being used currently is based on the social functioning questionnaire. It is appropriate

to the needs of the client group and is reviewed monthly. It does not contain a risk assessment. There is no key nurse system in place.

REHABILITATION TEAM

There is no dedicated rehabilitation team. There are two staff nurses on duty in the daytime and two at night. There is one attendant and one chef on duty. The consultant psychiatrist is available weekly when he attends the outpatient clinic. All residents are registered with a GP and can access the GP as required. There is no access to occupational therapy or clinical psychology. Referrals are sent to the social worker if necessary.

INVOLVEMENT IN REHABILITATION PROGRAMMES

All residents are required to be out of the residence during the day. Up to 12 residents attend industrial therapy at the Killeen workshop on the grounds of Our Lady's Hospital, to which they travel by taxi. One person attends the day centre, one attends the National Learning Network centre and one visits family daily. Staff remain on site.

UNIT MANAGEMENT

The residence has an ethos of continuing care, with two beds only involved in active discharge. The nursing staff are consistent and are rostered centrally. The household staff including the chef and cleaner is also consistent to the house. Nurses are dressed in casual dress and there are no uniforms. There are no specific policies dedicated to the residence. Informally residents are asked about their level of satisfaction with the quality of care. One resident was discharged last year and one is currently awaiting return to an independent flat.

HOUSE RULES

There is a Millfield House Resident Agreement which includes the house rules. They must be signed by all new clients and witnessed by the charge nurse. The rules are designed by the nursing staff and there are

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no set review dates. Visiting times are flexible. The residents do not have a front door key but they can lock the bathroom door and their bedroom doors. Residents are allowed to leave unsupervised, though many check in to let staff know where they are going. Meals are prepared by the chef on site. Residents have some role in meal planning and shopping. They can access the kitchen to make hot drinks as required. There are no set bedtimes and residents are not allowed smoke in their rooms. The residence has no single rooms so residents must share any of a double room or one of the three triple rooms.

Residents all manage their own finances. However, some choose to lodge money with staff in the residence. There is a record book in place for this. All residents are in receipt of benefits and many have post office accounts. Currently, residents are not paying any rent charges. Residents have not received any information regarding this process. Residents buy their own clothes independently in the local shopping areas. The residence has a standing agreement with local shops and local cash and carry. There is a petty cash system in place. Residents access the local community, the shopping centre, and take a taxi to town or visit the local pub. A number of the women are members of the local Pioneer group. Facilities are within walking distance and the residence also has access to a minibus purchased by the Mental Health Association for outings

SERVICE USER INVOLVEMENT

There are no community meetings; complaints are dealt with locally and are rare. All are registered to vote. Information is given only on request.

RECORDS

Residents do not access their files and do not write into their own files. The medical notes are of a very poor standard. There are no active reviews evident in the medical chart. Many residents have gone for a considerable period of time with no review in place. Medications have not been rewritten and some are dated back to 2002. The nursing files are current and up to date. They are based on a social functioning questionnaire. They are reviewed monthly and the client is asked to countersign that monthly review.

ENVIRONMENT

The house is pleasant although its location on the grounds of an industrial estate is very poor. There is a large side and rear garden which is maintained to a high standard. The house has many uses and this makes it difficult for the residents. The day centre uses a visitors' room, the multipurpose room and also the kitchen. The outpatient clinic is held every Tuesday morning. There is plenty of personal storage and there are internal and external smoking areas.

STAFF TRAINING

Staff receive no ongoing training and rehabilitation. They are offered courses in cardio-pulmonary resuscitation, fire safety, and control and restraint although none of these are compulsory.

ST COLEMAN'S HOUSE

Date of inspection: 6th July 2005

Number of beds: 16

DESCRIPTION

St. Coleman's House is a 16-bed residence with 24-hour nursing staff supervision, with one respite bed. There are currently 12 male residents and four female residents. The residence opened in 1996 and is situated close to town.

REFERRAL

The population of this residence is very static. It has an ageing population who have been in the residence since it opened. However, when there is a vacancy, the sources of referral are the acute unit in St. Michael's, community mental health nurses, consultant psychiatrists and outpatient clinics. The referral process is as follows: contact from one consultant psychiatrist to the consultant psychiatrist with responsibility for the residence, who then carries out an assessment. There doesn't appear to be any input into the assessments from the nursing team within the residence.

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PROCESS OF ADMISSION

The residence does have a policy regarding admission but it is very infrequently used due to the static population of the residents. The staff described a gradual process of familiarisation with the residence for any potential new resident. The only exclusion criterion is a recent history of violence. The main reason for admission to this residence at present is for former long-stay patients of Our Lady's Hospital to be introduced into the community. However there do not appear to be any active rehabilitation programmes implemented for this client group. The residence is not used as an alternative to acute admission. It is occasionally used for respite care.

On admission, the staff carry out a social functioning questionnaire and it was explained that the consultant would have seen the patient prior to the transfer at the source of referral. Physical examinations are carried out by GP. There are four GPs in the town and residents can have access to any of these practices. The consultant psychiatrist makes the decision to admit to the residence. For any new admission the staff attempt to involve the resident as much as possible. They also try to keep family members in contact. It was reported by the nursing staff that the consultant reviews residents every week and that the initial treatment plan is documented in the nursing and medical notes.

CARE PLAN

The care plans within the residence are nurse-led. Some care plans are in need of updating. A number of needs were identified a few years ago and although there is some evidence of reviews of care plans a more thorough up-to-date assessment is needed for some of the residents. There is no identified key worker system in place within the residence. It was stated that the care plans are reviewed every six months. There is no documented participation by residents in the care plans or input of any family member.

It is unusual for anybody to be discharged from this residence. A number of reasons were given for this; there is very little accommodation at a lower level of support for people to move on to and also due to the functioning of the resident group. As stated earlier the residents are becoming an elderly

population and when they moved from Our Lady's Hospital the residents were informed that this would be their home for life. It was estimated by the staff that four people could move on to accommodation of a lower level of support if it were available.

NURSING PROCESS

The staff claim to be using the Tidal model though there is little evidence written in the notes to support this. There is no formal risk assessment, the staff claim that they use an informal process.

REHABILITATION TEAM

There is no clinical psychology input, there is access to occupational therapy at the local day centre and there is some access to a social worker. One consultant psychiatrist who has overall responsibility for the residence attends the residence on a weekly basis. As stated earlier there are four GP practices locally to which the residents have access. The nursing staff in the residence are all qualified and there are two on each shift. The residence also has access to a dietician, physiotherapy and the local health centre.

INVOLVEMENT IN REHABILITATION PROGRAMMES

There is little evidence of needs-based individual programmes. The residents are encouraged to attend the day centre just down the road and to carry out household tasks. It was stated that due to the elderly nature of the majority of the residents, the residents seem content with the programmes they are involved in.

UNIT MANAGEMENT

There are no transfers, temporary or long-term from this residence to accommodate other people due to bed pressures. The skill mix in the residence is all qualified nursing staff and it was stated there are two staff on during the day and night. The unit has its own core staff group and covers annual leave and sickness itself. There is one cook and a cleaner on duty throughout the day.

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The ethos of the residence is continuing residential care. The staff are all fully inducted into the working practices of the residence as are the residents and the majority of the residents have been there since the residence opened. There are policies and procedure present. The female staff currently wear uniform but the male staff wear casual clothes. Maintenance is carried out by the HSE and the household staff are employed by the HSE.

HOUSE RULES

There are very few house rules within the residence. The main emphasis focuses on containing the smoking as the majority of residents smoke. The visiting times to the residence are flexible. The residents do not have a front door key and it was explained that the door is kept open until night time. Residents can lock the bathroom door but not their bedroom doors. Residents are allowed to leave unsupervised and they are asked to state where they are going and what time they will be back to a member of staff. It is the residents' choice whether they are out during the day or whether they remain in the residence. Food is prepared by a cook on site and the residents are involved in helping prepare the meals. There is some limited involvement in menu planning and shopping. Residents have free access to the kitchen to make drinks and snacks. Residents are not required to go to bed or to get up at set times. They have no choice in who they share with; there is only one single room and this is used for respite. Visitors can not stay overnight and residents are not allowed to smoke in their bedrooms.

Residents manage their own finances to the best of their abilities. Some of the residents request staff to look after their money for them and there is a written record of this. All residents have their own bank accounts or savings account into where their benefits are paid, currently they do not pay anything towards their keep. Prior to this, they paid €50.70 per week. Residents are able to buy their own clothes from local shops and are encouraged to look after their own clothes.

The residents use the community resources in the area. They go to the local shops, cafes and the day centre in the town. A number of the residents also use the public transport to go into Cork on

excursions. All the local facilities are within walking distance of the residence.

SERVICE USER INVOLVEMENT

There is some information available on drug treatments for the residents and also information on their rights. All the residents are registered to vote and it is their choice whether they exercise this right. There is a complaints policy in place which is the HSE policy and there is some information available.

RECORDS

Residents do not access their file or write in it. The files were legible though a number of them did contain loose pages. The resident's name and ID number was on the majority of the pages and each entry was signed and dated. There were no progress reports from allied health professionals and very little evidence of any treatment plans. The only written interventions were when a consultant psychiatrist or doctor was asked to see a resident. It was reported that the consultant attends weekly but there is nothing written in the notes to support this. The residents access the GP surgery, as already stated. The nursing files were all legible and tidy and had signed interventions. The majority of files inspected had social functioning questionnaires carried out a number of years ago – these need to be updated.

With regard to the medication system, there was a policy on self-medication and there were only a few residents who self-medicated, the majority had staff dispense medication. Most of the medication sheets required rewriting.

ENVIRONMENT

There was a regular maintenance programme in place provided by the HSE. Hygiene and décor within the residence was very good and it was very nicely furnished. There was only one single bedroom, the rest were either double or triple bedrooms. All the sleeping accommodation was upstairs, which may become a problem when the physical state of a number of the elderly residents currently in the residence deteriorates. The residence consisted of

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two lounges, a separate smoking room, an office, a kitchen, a dining room, utility room, various store rooms, bedroom areas and numerous bathrooms and toilets. There was also a pleasant garden. All local facilities are within walking distance for the residents. There is also transport available.

CLINICAL RISK MANAGEMENT

There is a policy on risk management available. There are also policies on alcohol and illegal drugs and on residents missing from the residence.

It is not deemed necessary or appropriate to search residents so there is no policy on this. Any serious untoward incident is recorded on appropriate forms and sent to the Assistant Director of Nursing. There are courses and training days available for the staff in the residence but it is difficult to get cover to attend these courses.

ST STEPHENS HOSPITAL, NORTH CORK

UNIT 1

Date of inspection: 22nd June 2005

Number of beds: 5 male, 17 female

DESCRIPTION

This ward is a de-designated unit. It is described as an Alzheimer's unit catering for clients from all over the county, both long-stay and respite. The patients are deemed to be neither Voluntary nor Temporary. The patients here are managed by the Clinical Director for St. Stephen's Hospital. Occasionally there is one bed reserved for the consultant for Psychiatry of Later Life (POLL). This is an open ward in that people can freely enter the unit but patients cannot freely get out. This has been an Alzheimer's unit since 1980 following the transfer of the professorial psychiatric unit to Cork University Hospital. All the patients in this unit have Alzheimer's apart from one. A GP used to provide input to this unit and it initially had been planned to have a geriatrician managing it. This appears not to have happened for various reasons. Medical assistance is provided on request by the duty doctors who are on call. The staff reported this to be an unsatisfactory arrangement.

Follow-up information from the Clinical Director states that there is dedicated medical cover by one of the trainees (NCHD) who visits the unit twice weekly and responds to all the calls during working hours. A registrar is also reported as visiting the unit once weekly. Many nursing homes will not take these patients because they are considered to be disruptive. In Cork, St. Luke's in Mahon, a Church of Ireland nursing home, has beds for Alzheimer's patients with behavioural problems and the HSE has some beds there.

REFERRAL TO UNIT

Patients are referred to the Clinical Director generally via a consultant psychiatrist or geriatrician.

PROCESS OF ADMISSION

The assessment and plan for admission are undertaken prior to admission to the service. There are three respite beds in the unit.

CARE PLAN

There is no multidisciplinary team input to this unit.

NURSING PROCESS

The nursing staff employed here are generally trained nursing staff. They use the Roper Logan Tierney model. There are plans to introduce a modified care plan similar to the nursing care plan in St. Finbarr's hospital. There is no key worker system in operation. There are five nursing staff on duty in the daytime with four in the evening and two at night. Two hours' contract cleaning was provided per day and one attendant 24 hours a day.

ACCESS TO THERAPY

There is no access to a social worker or psychologist. Occupational therapists assess patients in this unit for special seating. The OT department has been involved in many multidisciplinary meetings regarding seating, environmental design and safety issues.

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ACCESS TO THERAPEUTIC PROGRAMMES

Approval has been given for an activity nurse (three hours a day) to work a five-day week and it is envisaged that occupational therapists will develop a programme for this nurse to implement. Nursing staff on the unit do reminiscence therapy and Sonas with the patients in the unit. Singing and music are also available. Patients are also invited to social activities in the recreation unit. Some patients are reported to attend a weekly Music Therapy Session in Unit 7.

CLINICAL RISK MANAGEMENT

There was no risk management policy available on the unit. The hospital safety statement applies. There is a fire alarm system but no other alarm. There are hospital-wide policies on patients absconding and the management of violent episodes. Neither physical nor mechanical restraint is used. There are formal procedures for the reporting of accidents and injuries involving patients. These are audited or reported to the Healthcare Risk Manager and debriefing and formal clinical review is provided after a serious incident.

UNIT MANAGEMENT

There are transfers to other units when the ward is unable to manage behaviourally disturbed patients. Staff are unit-rostered and report to the Director of Nursing for St. Stephen's Hospital. The Clinical Director manages the waiting list. Staff are satisfied with the availability of maintenance support and household cleaning arrangements. Visiting times are flexible.

RECORDS

The files examined were satisfactory. Medication administration and prescription records were up to date.

ENVIRONMENT

In general, the unit is extremely pleasant. There was a separate suite for people who are becoming

increasingly infirm and dying. Family facilities are provided. There is also a snoezelen room. The décor is pleasant. There are orientation boards clearly posted. There is no clerical support. There is good access to the outside garden area. The reception area is a clearly defined area. There is no receptionist. There is comfortable seating. There are no alarms. The doors are not locked. Interviews are conducted in the nurses' office. There are no single rooms apart from the reserved room for the suite. There are four to six patients in the dormitories. There is individual wardrobe space. The shower facilities are particularly good and there are gender-specific bathroom facilities with wheelchair access. The dining room has space to accommodate all patients in one sitting. It has table service and it is integrated. There is comfortable seating in the day room and the dining room. The day room has a TV set. Newspapers, TV and video are available. Magazines are provided. The nurses' station is at the entrance to the ward. It is confidential and there is adequate space and it has a telephone but no IT. There is no alarm system. There is no examination couch in the clinical room. Venepuncture and PEG (tube) feeding are carried out in this clinical room. cardio-pulmonary resuscitation equipment is reported as being available from an adjoining unit, which also has a defibrillator and a resuscitation trolley. Staff have a changing room, rest area, toilet and shower facilities.

STAFF TRAINING

Staff are satisfied with the training available. They have two study days per year. They undertake fire safety and manual handling training every two years.

UNIT 2

Date of inspection: 21st June 2005

Number of beds: 23

DESCRIPTION

This unit is described as a care of the elderly ward. On the day of inspection, there was one Temporary patient. There were 16 male patients and seven female patients.

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REFERRAL TO UNIT

Referrals are made following a team discussion with the consultant psychiatrist. The consultant psychiatrist makes a decision to admit with the agreement of the Clinical Director.

PROCESS OF ADMISSION

It is rare that any patient with a moderate intellectual disability is admitted to this service. If it is decided to admit a patient, the NCHD carries out a full psychiatric assessment, if this examination had not been carried out on the acute ward. The collateral history is usually taken before the patient arrives on this unit. None of the patients have GPs. The staff stated that they always explain to the patient why they are being admitted and try to keep them involved as much as possible. The consultant psychiatrist reviews the patient soon after admission. There are four consultants who have responsibility for patients on this ward. The treatment plan is documented in the notes. All the patients on this unit are on general observation and there is a key worker system in place.

CARE PLAN

Care plans on this unit are nurse-led. The staff are currently using the Roper Logan Tierney model but there is a pilot scheme in place looking at a more comprehensive care planning process. There is evidence of the involvement of patients in the care planning process, in particular the new pilot system. Within the new system, goals and objectives are clearly identified and the interventions written on a daily basis do pertain to the care plans. This is not the case for the old system of care planning.

NURSING PROCESS

Staff on the unit have traditionally used the Roper Logan Tierney model but they are piloting a new system. The new system is appropriate to the needs of the patients and there is a daily record sheet which clearly demonstrates the ongoing needs of the patient group.

ACCESS TO THERAPY

It was reported by the CNM2 that there is no occupational therapy input on the unit although this is needed. Access to a psychologist or social worker is through referral. It was reported that the consultant psychiatrists usually visit the ward every month although in the files reviewed there were few entries from the medical staff. The NCHD is responsible for maintaining the physical well-being of the patient and refers people to the local general hospital if appropriate. The unit has access to a physiotherapist twice a week, a dietician for advice, and access to a dentist and chiropodist.

ACCESS TO THERAPEUTIC PROGRAMMES

Some groups are run on the unit but there is need for occupational therapy input. Patients have access to a day therapy unit. Previously, occupational therapists have been involved in seating assessments for the patient group. This needs to continue on a regular basis.

CLINICAL RISK MANAGEMENT

There is a hospital policy on risk management. There is no alarm system in place on this unit. It was reported that it is not deemed appropriate to have an alcohol and illegal drugs policy on the ward but there is a hospital policy. There is a policy on patients going missing from the ward. If a patient refuses medication they are reviewed by a doctor. Mechanical restraint is not used on the unit. However one patient is in a chair that he could not get out of. It was stated that his physical needs dictated the use of this chair. Staff receive regular training on cardio-pulmonary resuscitation techniques and there is a record of the training kept in the central office. Staff also receive training through in-house system. The monitoring of serious incidents is recorded on appropriate forms which go to the consultant psychiatrist, Clinical Director, Assistant Director of Nursing and the Director of Nursing. However, it was reported by ward staff that no feedback is received on these forms and there is no review of any serious incidents, although it was pointed out on this ward there are very few incidents.

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UNIT MANAGEMENT

On occasion patients are moved to other units to facilitate other admissions. They are not moved to other hospitals. There are very few activities available on this unit for the patient group. Patients are allowed off the ward if they are escorted by a nurse. The staff are allocated to this unit by a central rostering system. There have been attempts to try and maintain core staff on this unit but this has failed to happen. It was suggested by the CNM2 that it would be more appropriate to have their own staff rostered on this unit. Maintenance is carried out by hospital maintenance staff, there is access to contract cleaners and regular household staff. There is open visiting to the unit, set meal times and free availability of snacks and drinks.

SERVICE USER INVOLVEMENT

There is little evidence of any service user involvement. Although it is reported that service users are involved in their care plans there is no evidence of any information on treatment or therapies being available to the patients or their family members. There was no evidence of the availability of information on patients' rights, or any information leaflets. There is a complaints policy in place and complaints are followed up. There is access to advocacy.

RECORDS

The patient's name and ID number are on most pages of the files. Files were legible and were reasonably tidy. All entries had full name and title of the personnel but they did not contain any progress reports from a social worker, occupational therapist or psychologist. There was little evidence of any treatment plans. The majority of the written interventions were the six-monthly reviews or where a doctor was asked to see the patient. There are two systems of nursing files in use on this ward. A number of drug charts are out of date and need to be rewritten. In the chart of a patient who is currently detained it was difficult to find any information regarding his detention. It was evident that he came into the hospital voluntarily but there is limited information as to the reasons why his status was changed to Temporary.

ENVIRONMENT

This was a 23-bed care of the elderly ward situated in a psychiatric hospital. There was disabled access. There was a regular maintenance programme. The lighting and ventilation were good and the décor was also good. There was a long corridor through the centre of the ward, which was very nicely decorated and maintained. There was a designated visitors' area, which proved to be very popular with visitors. Bedroom areas were given limited privacy. There were four 6-bed dormitories and two individual rooms. The dormitories had curtains around the beds, which was a recent innovation and offered a modicum of privacy. There was wardrobe space and the décor was good in the dormitories. The two single rooms were of adequate size and it was noted on one of them that the roof needed to be repainted as the paint was peeling off. There were sufficient toilets and bathrooms to meet the needs of this unit. The bathroom had a modern bath and there was a freely accessible shower. The toilets were gender specific and although there was a missing toilet seat they were usually well maintained. There were specific bathing times although a number of patients have frequent baths due to their incontinence. There were overriding locks on the bathrooms doors.

There was one dining area, which had places for all patients at one sitting, although a number of the patients needed to be fed. There were two lounges, both nicely furnished and made to feel homely. The nurses' station was at the end of the main corridor. It was of adequate size, appeared to be confidential and there was adequate space for report writing. There was a phone system but no IT. The clinical room was situated in the centre of a main corridor. There was also a clinical store containing all the dressings. There was adequate storage on this unit.

STAFF TRAINING

There is an in-house programme of training and the training record for the year 2004 which had a very comprehensive range of training available to the nursing staff.

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UNIT 3 (ACUTE ADMISSION UNIT)

Date of inspection: 21st June 2005

Number of beds: 13 male

DESCRIPTION

Unit 3 is an acute admission unit for men. It is a single-storey, stand-alone building, situated on the grounds of St. Stephen's Hospital. On the day of inspection, there were 12 Voluntary patients and one Temporary patient.

REFERRAL

GPs refer people either by referral letter or by telephone contact with the community nurse or one of the team doctors. Some referrals come from Mallow General Hospital via the liaison service. Some people present themselves to the unit for assessment. Many of the referrals to the unit come from the sector teams.

PROCESS OF ADMISSION

There is an admission policy available on the unit. It dates from 1996 and gives general guidelines on who should be admitted. There have been no admissions of children under 16 years of age. People with moderate intellectual disability are occasionally admitted to the unit and remain under the care of the admitting consultant psychiatrist. Staff reported that there are good links with the voluntary services for people with intellectual disabilities. Patients are not admitted for uncomplicated alcohol detoxification. People who present for admission undergo an assessment by the doctor on call. A record is kept on the unit of all those who are assessed even if they are not admitted. Not all admissions are discussed with the consultant psychiatrist. The referring GP is contacted by phone if the person is not admitted. The admitting doctor discusses the initial treatment with the patient and normally asks the patient for permission to liaise with the family. Almost all admissions are seen within 24 hours by the consultant psychiatrist. Patients are sometimes nursed in their night clothes following admission. A key nurse is assigned to the patient on admission.

CARE PLAN

There was no evidence of multidisciplinary care planning on the unit. Following the assessment by the admitting doctor, a nursing care plan is drawn up with the involvement of the patient. This nursing care plan is reviewed after one week. There is multidisciplinary discussion of patients who are attending Unit 7 for therapeutic activities. One staff member from the unit attends this weekly meeting. Treatment plans of patients are discussed at the weekly team meetings. Families and carers may be involved in the care planning process. There is a discharge policy and a discharge form for communication with the GP and outpatient clinic.

NURSING PROCESS

The nursing model used on the unit is the Roper Logan Tierney model. Staff intend to change to the Tidal model in the near future as they view this as more appropriate to the needs of the patient group. There is no formal risk assessment in use. There are two levels of observation: general observation and one-to-one (special) observation. Discussion has been taking place about a new observation policy.

ACCESS TO THERAPY

Patients come into contact with an occupational therapist if they are referred to Unit 7 or if they attend the day hospital. Referrals can be made to a social worker or psychologist, who will visit the unit if required. The consultant psychiatrists conduct ward rounds on Mondays and Fridays and visit patients on the unit on other days if necessary. Community nursing staff visit the unit daily. An NCHD attends the unit daily. All medical and surgical emergencies are seen in Cork University Hospital or the Mercy Hospital. It was reported that there can be a delay in receiving laboratory results and that no computer-aided results service connected to the laboratory is available.

ACCESS TO THERAPEUTIC PROGRAMMES

A relaxation group and some leisure activities are provided on the unit. Some patients are referred to

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Unit 7, which can be accessed by a bus service within the hospital campus. Unit 7 is staffed by occupational therapists and nurses, who provide a range of individual assessments and interventions for a mixed group of in-patients and outpatients. An individual care plan is formulated for each patient and referrals can be made to community services if appropriate. One of the patients interviewed during the inspection had been on the unit for some weeks but had not been referred to Unit 7 and complained of boredom during the day.

ECT

This treatment is provided in Unit 4. Preparatory checks are done in Unit 3 and a nurse accompanies the patient to Unit 4.

SECLUSION

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

CLINICAL RISK MANAGEMENT

There is a policy on clinical risk management in the hospital. A pinpoint alarm system is in use. Staff from Units 4 and 5 respond to this alarm. There are policies available on alcohol and illegal drugs, patients going missing, the management of violent episodes and on giving medication without consent. All the belongings of a patient are logged in a property book on admission. Belongings are not normally searched thereafter. Serious incidents are recorded and this data is collected for action and for audit purposes.

UNIT MANAGEMENT

There are transfers to other units for a variety of reasons. Due to overcrowding, patients are sometimes transferred to Units 10 and 11, where single rooms are available. For reasons of safety, patients are sometimes transferred to Unit 4 and if patients are very disruptive and unmanageable on the unit, they are transferred to Carraig Mór. The

door to the unit is open during the day and locked at night. There is central rostering of staff to the unit. The staff complement is three nurses, one attendant and two contract cleaners (two hours) during the day and two nurses at night. The dress code for the nursing staff is that women wear uniforms and men dress smartly. There is no ward clerk but clerical support is available for a short period each day. Phlebotomy services are provided by the NCHDs and some of the nursing staff. There is sometimes a waiting list for the unit and this is managed by the CNM2. On the day of inspection, there was one patient whose discharge was delayed due to lack of appropriate placement. Visiting times are flexible. There is free availability of drinks and snacks. Meal times are 0900h, 1215h and 1700h.

SERVICE USER INVOLVEMENT

There were lots of information leaflets about the mental health service and other social and health services available for patients. There is a complaints procedure. An information booklet about the hospital and its services is available for patients and visitors. There is no formal way of seeking the views of service users or their carers on the service. There is regular access to an advocate from the Irish Advocacy Network. A number of patients were interviewed and all said that they were happy with the quality of care that they were receiving on the unit.

RECORDS

The patients' files were tidy and manageable. The front covers contained the patients' names and hospital IDs. Entries were all dated and signed but not all signatures were legible nor was the person's title always used. Each file contained a four-page admission assessment form and a discharge sheet. The files contained treatment plans, progress reports and regular consultant reviews. NCHD entries were more frequent. The nursing notes were signed, dated and legible but full names and titles were not always used. The files that were inspected contained no entries from social workers, occupational therapists or psychologists. A signature bank was being prepared. A card index system was used for medication. The prescription and administration sheets were in good order, the generic names of

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drugs were used and the discontinuation of medication was signed and dated.

ENVIRONMENT

Unit 3 was quite spacious with a wide corridor and rooms on either side. The unit was also very bright with large windows throughout. The door to the unit was unlocked. The nursing station was located near the door to the unit. It was of sufficient size but had no computer or fax machine. In front of the nursing station was a display of leaflets and policies for patients. The lounge and dining areas were quite large and nicely decorated. The sleeping areas were mainly 4-bed rooms, which were spacious and had previously been used to accommodate more patients. One of the large bedrooms had only one bed. There was a shortage of single rooms for those who might need them. There was no seclusion room and no high observation area in the unit. TV, books and newspapers were available on the unit. There was no examination couch. There were a number of offices at the end of the unit that were suitable for interviewing.

UNIT 4 (ACUTE ADMISSION UNIT)

Date of inspection: 21st June 2005

Number of beds: 22

DESCRIPTION

Unit 4 is an acute admission unit with predominantly female patients. However, there are a number of male beds on the unit. At the time of inspection there were four male patients on the unit. The unit is a standalone unit located in the grounds of St. Stephen's Hospital and is an open unit.

REFERRAL

The majority of referrals to the admission unit are from GPs. The remainder of referrals come through the outpatients department, community mental health nurses and by self-referrals.

PROCESS OF ADMISSION

There are no admissions of children under 16 years of age. People with moderate intellectual disability are only admitted if they have previously been a patient of the service. Patients are not normally admitted for uncomplicated alcohol detoxification. Occasionally patients are admitted for social crisis rather than for treatment of a mental illness. All patients receive a psychiatric assessment and physical assessment on admission and an initial treatment plan is devised. The non-consultant hospital doctor contacts the consultant psychiatrist in the majority of admissions. The patient is reviewed by the consultant psychiatrist within 24 hours of admission. There is no policy of keeping patients in their night clothes following admission.

CARE PLAN

There is no multidisciplinary care planning in the unit but there is a nursing care plan. Multidisciplinary team meetings take place on Unit 7 (occupational therapy department). These meetings are attended by the patient's key nurse. There is a discharge plan in the clinical file and in the nursing care plan. Discharges are decided at the team meetings. A discharge letter is sent to the patient's GP immediately following the patient's discharge.

NURSING PROCESS

The nursing model used on the unit is the Tidal model. It was felt by staff that this was appropriate to the needs of the patients. There was a key worker system in place based on sectors. There are two levels of observation: general observation and one-to-one observation. There are four nursing staff on duty in the daytime and two staff on duty at night.

ACCESS TO THERAPY

The patients have access to occupational therapy through the occupational therapy department in Unit 7. There is a psychologist available on each sector team. There is only one social worker within the whole service, who is able to provide an emergency service only. The consultant psychiatrist is available on

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the unit twice a week and the NCHD reviews patients daily. Patients and accompanying staff have to wait for long periods in the A&E department of the general hospital services for medical and surgical consultations. There is good access to radiology and laboratory services. The Refocusing Acute Psychiatry Project will be initiated in the near future, and this aims to increase and formalise patient contact with nursing staff.

ACCESS TO THERAPEUTIC PROGRAMME

Access to therapeutic activities is through Unit 7, which is an occupational therapy unit. This is staffed by an occupational therapist and nursing staff. Patients are referred to Unit 7 by referral form and are assessed by the occupational therapist. Following assessment the unit offers therapies such as relaxation, art therapy, exercise, daily living skills and gardening. Patients are engaged also in repetitive tasks such as packing dressing into bags for the hospital services. The occupational therapy department is a large unit with plenty of space for a large number of activities and has a garden area. There is no formal routine mechanism for daily reporting of patients' progress, behaviour and mental state to the staff on the admission unit. Reports are telephoned to the ward staff only if the staff in the occupational therapy unit are concerned about a patient's behaviour. Staff from occupational therapy also attend the weekly team meetings.

ECT

ECT is carried out on the unit. However the facilities are substandard. There is a small ECT treatment room, which is equipped for administering ECT. There is no waiting room, no preparation room and no recovery room. This is unsatisfactory for administering ECT. There is an ECT register and pre-ECT checklist. There is a consultant psychiatrist with responsibility for ECT, but there is no designated ECT nurse and nurses have not been specifically trained in ECT procedure.

CLINICAL RISK MANAGEMENT

Policies were available on the unit. However the majority of the policies available on the ward dated back to 1996 and were out of date and inadequate. New policies are being drawn up at present. It was reported that there was a hospital policy in risk management, which applies to this ward. Some staff are trained in control and restraint techniques. Most staff are trained in breakaway techniques and cardio-pulmonary resuscitation. There is a system of reporting serious incidents with feedback to the unit. There is a very comprehensive pinpoint alarm system on the unit with response from Unit 3, which is next door.

UNIT MANAGEMENT

Occasionally patients are temporarily transferred to other wards due to bed shortages. Patients are also transferred from the male admission unit (Unit 3) due to bed shortages. This can lead to some difficulties in sleeping arrangements, as the unit design is not suitable for gender integration. There is no waiting list for the unit. There are approximately four patients waiting for appropriate alternative placement. The ward is open and patients are free to leave the unit. There is no CCTV in the unit. Staffing is through central rostering, which causes difficulties for continuity of care. There is no ward clerk available to the unit. There is one household staff on duty during the day with two hours cleaning provided by contract workers. The nursing staff are trained to carry out phlebotomy. There are open visiting times. There is no information technology in the unit.

SERVICE USER INVOLVEMENT

There were information leaflets about the service available. Patients' rights under the Mental Treatment Act 1945 were displayed. There was a complaints procedure available for patients. There was access to patients' advocacy services. Patients who were interviewed complained that there was no smoking room and no availability of coffee and tea outside scheduled times.

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RECORD

The patients' clinical files were well maintained. The files were tidy, manageable and legible. All entries were signed and dated and the files contained treatment plans. There were entries by the consultant psychiatrist at least twice weekly. The nursing files were also satisfactory. Reviews of the nursing care plans were up to date. Medication sheets were signed and dated. Signatures were not always legible. There was no signature bank available. Discontinuation of medication was signed and dated.

ENVIRONMENT

The unit was a single-storey building situated in the grounds of a large psychiatric hospital. The patients had access to extensive grounds but were some distance from the nearest town. The unit had recently undergone renovations and redecoration. The unit consisted of a long corridor with rooms off each side and a veranda running along one side. The lounge area was nicely decorated but the chairs were institutional in type. There was a flame-effect gas fire, which gave a homely feel. The veranda area was pleasant and provided a quiet area. Smoking was permitted outside only. There were plans to equip an area as a small gym and staff were actively fund-raising for this. There were single rooms as well as 4-bed and 6-bed rooms with en-suite bathrooms. There was a group room for different activities. The bathrooms and toilets were adequate and there was disabled access. There was an adequately provided surgery. The kitchen and dining rooms were satisfactory. There was a reasonably sized nurses office with adequate storage space. A new observation office had been constructed which looked onto two 4-bed dormitories. This was not in use as there have been difficulties with soundproofing this office.

UNIT 5

Date of inspection: 22nd June 2005

Number of beds: 14

DESCRIPTION

This unit is described as a high dependency unit for 14 male patients, although there were 15 on the day of inspection. There were three Temporary patients and one Ward of Court.

REFERRAL

The source of referral to this unit is from other wards within the hospital. The process of referral is consultant psychiatrist to consultant psychiatrist.

PROCESS OF ADMISSION

There are two people with a moderate intellectual disability on this unit. It is recognised by staff that these patients' needs could be more appropriately met in a learning disability service, but requests for this have failed. On transfer to this unit, a psychiatric assessment is made by the NCHD and the consultant psychiatrist reviews the patient within two to three days. A physical examination and collateral history is taken on the previous ward. The decision to make a transfer to this unit is made by the consultant psychiatrist. Family members are notified of the transfer. An initial treatment plan is documented in the case notes and nursing notes. It is rare for a patient to be on any special observation on this unit and they are all usually on general observation. There is a key worker allocated on admission.

CARE PLAN

The care plans on this unit are nurse based. A new system has recently been introduced and this provides a thorough assessment; the patient is involved where possible. Goals and objectives are identified by the key worker. Care plans are reviewed on an ongoing basis, usually three to six months and are documented in the nursing notes.

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There are no immediate plans to discharge any of the patients on Unit 5.

NURSING PROCESS

There is no recognised nursing model used on the unit although there is a very thorough assessment, which leads to care plans being implemented. There are some elements of risk assessment carried out and the care plans seem to be appropriate to the patients needs.

ACCESS TO THERAPY

There are two occupational therapy sessions a week on the unit and as well as art therapy and music therapy. For social worker and psychologist input a referral must be made. There is very limited evidence of any input from the social worker or psychologist. There are four consultant psychiatrists who have patients on this unit and the minimum frequency of consultant review is six-monthly. Any physical conditions are monitored and addressed by the NCHD who visits weekly, or the patient is transferred to the general hospital. There is some physiotherapy input onto this unit.

ACCESS TO THERAPEUTIC PROGRAMMES

There are some groups happening on the ward and a number of the patients attend the recreation centre.

CLINICAL RISK MANAGEMENT

There is a risk policy in place on clinical risk management. There is an alarm system in operation. There is an alcohol and illegal drugs policy and a patient missing policy. There is very little violence or aggression on this unit but there is a hospital-wide policy in place. Neither mechanical nor physical restraint is used on the ward. Some of the staff are trained in control and restraint techniques but not all. There is an in-house training programme for cardio-pulmonary resuscitation and there are other study days available. Any untoward incidents are recorded on the appropriate forms which go to the Director of Nursing and the Clinical Director.

UNIT MANAGEMENT

Patients are never transferred from this unit to other units because of pressure on beds. There are some activities available on the unit such as art and music. Patients are allowed off the ward for set periods of time and there is an enclosed garden, to which the patients have free access. On the day of inspection, the door was open but it is locked when staff are covering meal breaks and at night. There are four staff on duty during the day and two at night. One of these is a qualified nurse and one is an attendant. The unit is managed by a central rostering system but there are core staff available. There is one household staff and a contract cleaner. There are no formal plans to discharge any of the patients from this unit. It was reported that a number of the patients could move on to other placements if the appropriate rehabilitation programme was in place. There are flexible visiting arrangements and visitors are encouraged to come on to the ward. There is a pleasant visitors' room, which is very well maintained and furnished. There are set meal times but there is free availability of snacks and drinks.

SERVICE USER INVOLVEMENT

There is very little evidence of any service user involvement. There is no information on treatment or therapies and there was no information displayed on patients' rights. There is a complaints procedure. There is access to advocacy.

RECORDS

In the medical files most of the pages have the patient's name and ID number on them and they are legible and reasonably tidy. Not all entries have the full name and title of the personnel. They are signed and dated however. There were no progress reports from social work, occupational therapists and psychologists. Treatment plans are generally evident in the case notes but there are very few written interventions from the medical team. Usually it is only at the six-monthly review and whenever there are any requests to see the patient from the nursing staff. Nursing files are clear and legible and tidy. They have introduced a new system of care planning, which, although is in its early stages, appears to be effective.

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Medication charts were all signed, dated and legible. They had recently been rewritten. The chart of the person who was involuntarily detained was reviewed and there was very little information regarding their detention.

ENVIRONMENT

This was a fourteen-bed unit although there were fifteen patients in it at the time of inspection. It was situated in the grounds of St. Stephen's Hospital and catered for people who were deemed to be highly dependent. There were regular maintenance programmes and there was disabled access throughout the unit. There was good lighting, ventilation and the décor was of a good standard. The corridor was a long central corridor with nice furniture and it was well maintained. It was a very quiet unit and there was music playing at a reasonable level, which the patients seemed to enjoy. There was a designated visitors' area, which was extremely pleasant. There was access to a secure garden, which was beautifully maintained. The bedroom areas were in 4-bed dormitories. Patients all had curtains around their beds and they had their own wardrobe space. The décor was good and the rooms were extremely tidy and clean. Toilets and bathroom décor was satisfactory. In these areas there was free access and there were overriding locks on the doors.

The dining area had sufficient room to accommodate all patients in one sitting and the majority of the patients are served their food. There is some choice and the décor was good. The lounge areas had comfortable seating and there was access to a TV and radio. There was a daily newspaper delivered and there was a supply of books for the patients. There was a quiet area, which had comfortable seating and also seemed to be well decorated. The nursing station was situated at the end of the corridor by the entrance to the ward. It appeared to be confidential and had sufficient space for report writing and was accessible. There was a telephone system but no IT. The clinical room was situated in the middle of the ward and had all the appropriate equipment and drug storage. There was sufficient storage in this unit for medication, catering and linen. The patients' money was held in an account in the general office and a supply of money was sent on a weekly basis.

UNIT 8 (SECOND FLOOR)

Date of inspection: No date given

Number of beds: 21 integrated

DESCRIPTION

The function of the unit is the care of high dependency elderly patients. Twenty of the patients are more than 65 years old. The youngest patient in this ward is 57 years of age. Patients are transferred to this ward if their dependency needs increase. This ward should ideally be under the care of a Psychiatry of Later Life (POLL) consultant psychiatrist and have input of a full multidisciplinary team. There was one patient on Temporary status and three Wards of Court on the day of inspection.

REFERRAL

Patients are transferred to this ward by their own team if their dependency needs increase. They are managed there by their own sector consultant. There are four teams currently admitting to this unit. Patients have been assessed or are well known to the service prior to transfer or admission to this unit.

PROCESS OF ADMISSION

There was no unit-specific referral and admission policy documenting the procedure for referral and admission. It was reported that "acute" patients were not admitted. Many of the patients were transferred from other units within the service. Patients are assessed prior to admission by the consultant, social worker or community nurse. A physical examination was carried out on the unit by the duty doctor and the person making the decision to admit was the sector consultant psychiatrist. The family may visit the unit prior to admission. Key workers are allocated on admission according to the sector from which the patient originates. There is no formal policy regarding nursing in night clothes, which may be used following admission.

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CARE PLAN

There was no formal multidisciplinary team care planning.

NURSING PROCESS

The nursing model in use was an adaptation of the Nancy Roper care plan. At the time of inspection, a new nursing care plan was being piloted and there were written guidelines regarding the implementation of this. A copy of the "patient assessment and nursing care plan" was available on the unit and was dated April 2005. Staff are keen to introduce this system and they feel it is much more appropriate to the needs of their patients. While it does not contain a formalised risk assessment system, there are areas relating to maintaining a safe environment. There is no up-to-date observation policy as apparently this the source of some conflict between the unions representing the nursing staff and management. All staff wear name badges.

ACCESS TO THERAPY

There are no occupational therapists, social workers or psychologists available to the unit. Patients can be referred to a psychologist and will be seen off the unit. There is one social worker for North Cork who does perform assessments when requested, although there is a waiting list. There is no occupational therapy service available on the unit. One patient goes to the recreation unit where there is some occupational therapy input. There is some behaviour therapy input. Psychiatric review in general is infrequent and it was reported that it was sometimes difficult to access NCHDs and get continuity of care. Apart from one sector consultant who attends on a weekly basis, review by a consultant psychiatrist is infrequent. It has been reported since the inspection that all of the long-stay wards were visited at least weekly by NCHDs and by consultant psychiatrist staff with a minimum six-monthly interval. Access to medical and surgical consultation and obtaining laboratory results is satisfactory.

ACCESS TO THERAPEUTIC PROGRAMMES

Sonos is provided a few times per week. Reminiscence therapy is conducted and videos are shown. There are walks, outings and visits to the sensory room in Unit 8.

CLINICAL RISK MANAGEMENT

The hospital safety statement applies. There is a fire alarm system but no other alarm. There are hospital-wide policies on patients absconding and management of violent episodes. Neither physical nor mechanical restraint is used. Staff have access to training in cardio-pulmonary resuscitation, control and restraint and de-escalation. There are formal procedures for the reporting of accidents and injuries involving patients. These are audited or reported to the Healthcare Risk Manager and debriefing and formal clinical review is provided after a serious incident. An induction manual is being developed for this unit and there was a staff induction booklet available on the ward on the day of inspection.

UNIT MANAGEMENT

There is no waiting list. Patients are not temporarily transferred to other units. Patients are occasionally transferred to Unit 2. Two to three of the patients go off the ward unescorted. The ward has a buzzer system allowing patients access to the ward. There is no CCTV on the ward. The ward is not used for any other purposes. None of the patients are considered to be awaiting appropriate discharge placement. There are five nursing staff on in the daytime with two nursing staff on by night from a central rostering system. Two hours of contract cleaning are provided each day. There is one attendant on duty day and night. Staff adhere to a dress code. There is no ward clerk available. Some of the nursing staff have trained in venepuncture and they and the NCHDs provide this service. Staff are satisfied with the level of backup provided by the maintenance, switchboard and household staff. The contract cleaning company has worked out well in the last year. There is extensive blue and red coding throughout the unit. There is also a recycling campaign throughout all parts of the hospital. Visiting times are flexible. For health and safety reasons patients cannot access the

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kitchen although staff facilitate as much as they can. Meals are at 0915h, 1215h and 1715h with regular snacks at 1100h, 1500h and 2030h.

SERVICE USER INVOLVEMENT

There are monthly unit community meetings with the patients. Advocacy is provided if requested. The advocate service visits the acute units. The hospital-wide complaints policy applies. There wasn't any evidence of information leaflets on the unit. Information on treatment and therapies is provided by the treating doctor.

RECORDS

The patient's name and ID number was not on all of the medical pages. The files were legible. A signature bank is available. Entries did not have the full names and titles of personnel and there were no progress reports from any social workers, occupational therapists or psychologists. There were progress reports. Medication allergy alerts were clearly documented. There was clear admission assessment by the doctor on a patient admitted this year with the referral source identified but the ICD DSM diagnosis was not documented. There were infrequent consultant psychiatrist notes in the charts. The generic names of drugs were not always used and drug names were not always legible. The dose and intervals were clearly written. The name of the doctor was not clearly identifiable. The administration sheet was legible and refusal of medication was noted. The discontinuation of medication was not always signed or dated. Twice-daily nursing reports are in the daily flow sheets and in the continuation sheets. These were satisfactory.

ENVIRONMENT

This ward was repainted last year but the paint needed redoing. It was a spacious unit on the second floor. The asbestos in the ceiling still needed to be removed. The unit had disabled access. The corridors were dark but were well-ventilated and of adequate width. There were information boards available in the smoking and non-smoking rooms. There was a

visitors' room, which was very sparsely furnished. Although this was a second-floor unit there was access to the garden via the elevators. There was one large male dormitory with eight beds. There was no evidence of any personal mementoes. There were four vacancies. There was one large female dormitory with ten beds. There were eight single rooms, four male and four female. There were curtains around the beds in the dormitories. There were glass panels in the doors of the side rooms. Some of these had curtains. There were individual wardrobes. The toilets and bathrooms décor was adequate. They were open all the time. There were no en-suite bathrooms. There were gender-specific bathrooms and toilet facilities with set bathing times. There was dining area space to accommodate all patients in one sitting with service being at the tables. There were attempts to make this more pleasant with photographs on the wall. The partition had been taken down and needed to be refitted. There was access to a snoezelen room downstairs and access to a shop. There was a TV in both the smoking and non-smoking rooms. One of the patients had his own TV and some had their own radios. The nurses' station was used as the interview room. This was centrally located. It was accessible, with space for report writing. There was no IT. There was a fire alarm but no personal alarm system. The clinical room did not contain a couch. It contained a defibrillator with cardio-pulmonary resuscitation equipment, oxygen suction and a system of bagging waste that allowed for tracking of hospital waste material. The standards in this area appeared very satisfactory. Staff facilities included a changing room, a rest room, toilet and showers. There was access to a library downstairs in the same building. Patients had their own lockers. Files and records were kept in the nurses' office, medication being kept in the clinical room and there was adequate space for this. Space available for catering and linen was satisfactory.

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UNIT 8 (THIRD FLOOR)

Date of inspection: 22nd June 2005

Number of beds: 26 integrated

DESCRIPTION

This unit is described as a high dependency psychogeriatric unit for ambulant patients who require a high degree of nursing input. Most of the patients here have been moved from Our Lady's Hospital. They range in age from 49 to 87 years. Seventeen of the patients are over the age of 65. There are no admissions to this unit, even for respite.

REFERRAL AND PROCESS OF ADMISSION

Not applicable.

CARE PLAN

There is no multidisciplinary care planning process for in-patients and no occupational therapist, social worker or psychologist input to the ward although patients can be referred to these departments.

NURSING PROCESS

The nursing model in use is a modified version of the Roper Logan Tierney model and the staff are satisfied with this. A key nurse is responsible for documenting this and there is a review of the care plan every three months. There is no formalised risk assessment but there is a key worker system, which is linked to the sector teams. The observation policy dates back to 1998 and there have been attempts to update the policy but this is the subject of some industrial relation issues. The staff wear name badges.

ACCESS TO THERAPY

Patients can be referred to the psychologist, occupational therapist or social worker. There are no visiting counsellors to the unit. Four consultant psychiatrists provide input to this unit, caring for the patients that come from their own particular sector.

The frequency of doctors' visits to the unit varies. It has been reported since the inspection that consultant psychiatrists review patients at least every six months. The staff are satisfied with the medical and surgical consultation backup available to them and laboratory and X-ray results are returned in a timely fashion.

ACCESS TO THERAPEUTIC PROGRAMMES

Seven or eight patients regularly attend programmes in the recreation unit. There is access to a multi-sensory room. There is newspaper reading and Sonas provided on the unit. A musician attends the unit once a week as part of the Cork City of Culture Year.

CLINICAL RISK MANAGEMENT

The HSE Area policy on risk management is available but there are no unit-specific policies. There are formal procedures for the reporting of accidents and injuries involving patients. These are audited or reported to the Healthcare Risk Manager and debriefing and formal clinical review is provided after a serious incident. Cork University Hospital provides a service to counsel staff who have been assaulted. It was stated, however, that they were slow to respond. Neither mechanical nor physical restraint is used. Training in control and restraint, de-escalation, breakaway techniques and cardio-pulmonary resuscitation is all available. Two of the staff have recently attended training in cardio-pulmonary resuscitation. Drug company representatives come to the admission units and provide updates on medication. Staff from the other wards attend these briefings.

UNIT MANAGEMENT

There is no waiting list. There are no temporary transfers or long-term transfers to other units. Patients have free access off the ward although the doorbell sounds as people come and go. The unit is locked only at night. There is no CCTV. The ward is not used for any other purposes. There are four nursing staff on day duty and two by night, with central rostering. Two hours of contract cleaning are

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supplied on a daily basis and there is one attendant in the kitchen in the daytime and an attendant also at night. There is an induction policy for new staff and an induction folder is being prepared. There is a dress code. There is no ward clerk and nursing staff are trained to take bloods. There are some patients awaiting appropriate discharge placement. One of the patients is inappropriately placed here although other placements have been sought for him. Staff are satisfied with the availability of non-clinical support such as maintenance, switchboard and the contract cleaning arrangements. The visiting times are between 1400h and 1600h and 1900h and 2000h and are flexible. Volunteers from the St. Vincent de Paul Society and the Legion of Mary regularly come to the unit. The staff make snacks and drinks for the patients. Due to safety regulations, patients are not allowed access to the kitchens. Meal times are at 0915h, 1215h and 1715h. There are snacks and drinks at 1100h and 1500h and at night.

SERVICE USER INVOLVEMENT

There was little evidence of service user involvement in the service. The hospital-wide complaints policy applied. An advocate is available if requested.

RECORDS

The case files inspected were satisfactory. There was evidence of physical assessments on admission. There was a nursing care plan in use. All entries were dated and signed. There were infrequent entries by the consultant psychiatrists in some files. Some medication administration sheets were out of date and discontinuing of medication was not always signed and dated. Generic names were not used. Nursing reports were done twice weekly, signed and dated and the name was legible.

ENVIRONMENT

The staff in this unit moved into the present location six months earlier and they had only recently been informed that they were going to stay there. Efforts had been made to make the unit more home-like and pleasant and there were now active plans to

refurbish the ward. It was a spacious third-floor unit with good disabled access. There were balcony areas at the back, the railings of which are currently being replaced. Lighting was satisfactory. The ventilation was good. There were wide corridors. There were no information boards. There was a visitors' area, which required refurbishment. The patients had free access to the outside. There was comfortable seating in the reception area, which was the wider part of the corridor outside the nurses' station. The doors were unlocked. There were ten single bedrooms, three being vacant. There were two dormitories with four patients. Some of the dormitories had beds that had evidently been vacant for some time. This militated against a homely environment. There was good wardrobe space. The décor was bare and needed upgrading.

There was one bath and one Parker bath for the entire unit, which was not satisfactory given the level of physical dependence of these clients. The ward required a shower. There were no en-suite bathrooms. There was one designated female toilet and washroom. There were two male designated toilets, which had overriding locks. The dining area, the décor of which needed upgrading, had space for all patients at one sitting. There was table service and there was a choice offered. There was one smoking and one non-smoking lounge area. TV and radio were available in both lounges. There was no video and very few books. Apart from the visitors' room, there was no other quiet area. The nurses' station was centrally located and was satisfactory. It was confidential, with space for report writing. It was accessible. It had two telephone lines, but no IT. There was no alarm system. The clinical room had an examination couch. PEG (tube) feeding and dressings were carried out there and medication was also kept there. The defibrillator for this unit is kept in Unit 4 although there was an emergency trolley in this unit. Cardio-pulmonary resuscitation equipment and oxygen was available. There was a staff area with a changing room, toilet, and a kitchenette. There was access to a library downstairs. Patients had individual lockers in their rooms with their own personal clothes. There was some personal clothing kept in a storeroom. There were separate stores for the linen. Files and records were kept in the nurses' office. Catering was by the cook-chill system.

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UNIT 10

Date of inspection: 21st June 2005

Number of beds: 17 male, 7 female

DESCRIPTION

This unit has been described as providing rehabilitation and continuing care for patients who are medium to high dependency. It currently has ten patients from North Cork, eleven from North Lee and three from West Cork. The plans are to move the majority of patients from this unit to the hostel in Kanturk when it opens. Each of the sector consultants care for their own patients. There were occasional admissions for respite – one admission occurring since last February. There are no detained patients on the ward.

REFERRAL

There were no direct acute admissions to this unit. There have been a couple of admissions for respite – two in 2004 and one in 2005.

PROCESS OF ADMISSION

There were no direct admissions to this unit and no Temporary patients are admitted to this unit or transferred here. If patients were admitted for respite the decision was made by the consultant psychiatrist and the patients had an assessment prior to admission and a physical examination performed following their admission.

CARE PLAN

There was no formal multidisciplinary care planning process for patients in this unit. Care plans are prepared after discussion among team members at the weekly team meeting attended by staff from the unit. Patients could be referred to the occupational therapist, psychologist and social worker if deemed appropriate. The occupational therapist attends the weekly review meetings. The psychologist and social worker did not routinely attend review meetings for these patients. Patients who attend Unit 7 from this

unit are discussed weekly at a multidisciplinary team meeting in Unit 7.

NURSING PROCESS

The model used was a modified version of the Roper Logan Tierney care plan. Unit 4 in the hospital was the only unit currently using the Tidal model and it was reviewed every six months. Nursing notes were written twice a week, on Wednesday and Saturday, and more frequently if events required that. They did not contain a formal risk assessment. There was no key worker system in place. Staff wore name badges.

ACCESS TO THERAPY

Patients could be referred to the psychologist. One of the occupational therapists attended from Unit 7 and assessed patients if requested. There was only one social worker for the entire North Cork Area but there was evidence of his input on the unit. The frequency of review by consultants was variable depending on the consultant involved. There was no difficulty in accessing laboratory and X-ray results and medical and surgical backup availability was described as excellent. Nursing staff on the unit were sometimes redeployed to other units both in the daytime and by night if there was a shortage of staff elsewhere in the hospital.

ACCESS TO THERAPEUTIC PROGRAMMES

There was no evidence of any needs-based group therapy. A number of patients were collected by the van every morning and brought to the recreation unit. The recreation unit was an activation and recreation unit for long-stay patients, with a particular emphasis on socialisation. There are multidisciplinary assessments of patients on that unit. An art therapist attended the recreation unit. As part of the Cork City of Culture Year, there was a music programme evident throughout the hospital. A musician came into the unit every Wednesday for a sing-song. There was a snoezelen room available in Unit 8 however this was difficult to access due to the level of physical dependence on the ward and the walking distance.

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CLINICAL RISK MANAGEMENT

All the policies in relation to risk were available on the ward. There was a pinpoint alarm system in operation, with an arranged response. The first alarm checked on the day did not work. There were hospital-wide alcohol and illegal drugs policies, policies on patients absconding and the management of violent episodes. Mechanical restraint was not used on this ward. If physical restraint was used it was documented in the clinical case notes. This would occur rarely. Training in control and restraint and de-escalation and breakaway techniques were all available. However, the staff said it was difficult to get the time to do it or time off in lieu. There was no regular updating on medication. The only documentation of risk noted in the nursing care plans related to that of smoking. A standard clinical form was used to investigate serious incidents and they were forwarded to the relevant personnel. Debriefing was available.

UNIT MANAGEMENT

There was no waiting list. Patients were never temporarily transferred to other units unless they acutely relapsed, in which case they would require an admission. There was one vacancy at the time of inspection. Occasionally patients moved from an acute ward to sleep over while making a vacancy. Long-term transfers to other units occurred when patients became increasingly infirm in which case they were transferred to a psychogeriatric ward or the Solas Nua, a 14-bed high support hostel. Activities available on the unit included newspaper reading and occasionally music. Patients had free access off the ward. The ward was an open unit being locked only at night. There was no CCTV. Two out-patients, who worked in the National Learning Network, attended the ward for medication and blood sugars. There were three nursing staff on in the daytime and two at night from the central rostering system. There was one household staff on and there was no formal induction for staff. There was a dress code. There was no ward clerk available. Doctors took bloods. Many of the nurses had done venepuncture courses recently. There was good access to maintenance support and usually when issues were raised they were attended to fairly quickly. It was noticed on the day that the grass was

quite long on certain parts of the surrounding areas and this had recently been brought to the attention of the gardeners. There were two hours of contract cleaning from 0900h to 1100h each day along with an attendant full time. Visiting times were flexible. Visitors usually go to the patient's room. Patients could not have access to the kitchen for health and safety reasons but staff tended to be obliging. Meals were at 0900h, 1215h and 1715h. A chiropodist and hairdresser attended the ward but had to be booked through the secretary or the Director of Nursing.

SERVICE USER INVOLVEMENT

Information on treatment and therapies was provided if requested. Carers' or family opinions were not actively sought but staff regularly met with those who visited. There were no unit community meetings with patients. Volunteers from the St. Vincent de Paul Society and Legion of Mary occasionally dropped in. There was good pastoral care available. The advocacy service did not appear to visit this unit.

RECORDS

Some of the charts were examined and the standard was very variable depending on which sector the patient belonged to. In some, the six-monthly physicals were not done and there was no evidence of regular physical or medical review by the consultant or the NCHD. Some were satisfactory in this regard. Occupational therapist, social worker and psychologist entries were available in the charts when assessments had been performed. Some of those were being prepared for move to the new hostel. A clear case summary was documented and filed in front of the chart. Spare information was kept in a sleeve in the back of the chart. Many of the drug prescriptions had not been rewritten in the last couple of years. Generic names should be used and the name of the doctor should be clearly identifiable. Discontinuation of medication was not signed or dated. Nursing notes were in the card index system and were done on a twice-weekly basis with a six-monthly review of the care plan. They were signed and dated.

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ENVIRONMENT

The unit was very spacious. It was situated on the ground floor of a three-storey building. The first floor being Unit 11 and the second floor being a living area for domestic staff still employed in the hospital. There was disabled access with a ramp at the front door but it was not fully wheelchair accessible. There was good lighting and ventilation and the décor was satisfactory. Corridors were appropriately wide. In the reception area or lobby to the unit there were information boards, detailing the date, the weather, the news and politics, for the day. This was a comfortable seating area. There were no brochures or information available. There was a visitors' area, a visitors' room and there was access to the garden at various points through the unit. This was an open unit. There was no separate interview room, the nurses' office being used for this purpose instead.

All bedrooms were single rooms, which afforded privacy. Some of the lockers were locked as were the wardrobes due to other patients interfering with people's belongings. The doors were open to the rooms throughout the day. The patients in Unit 11 tended to use the facilities on this ward, which meant that it was overcrowded at times. There were only two toilet-cum-shower areas, one of which was in the middle wing and was supposed to be for females only. However it was used by males both from upstairs and downstairs. To get to the shower or bath one had to pass in front of the toilets, which, despite having doors and locks, was not a satisfactory arrangement. Three of the female patients had commodes because of this problem because of their unwillingness to use the toilets. The toilets and bathrooms were not very appealing. They were left open throughout the day. There were no en-suite bathroom facilities. Although the toilets were intended to be gender specific, the males who are located in the east wing also used the toilet in the middle wing. There were overriding locks to the toilets and bathrooms were locked with combination locks known only to the staff. There were plans to convert a room into the clinic or surgery and perhaps the clinical room could then be converted into a shower.

The dining room, which was situated beside the dining room for Unit 11, had adequate space for all patients at one sitting. The dining area for Unit 11 looked much more appealing and was visible from

the other dining room. There was table service and they were integrated dining areas. There were no exercise or activity areas. With regard to lounge areas, the lobby area was non-smoking and had no TV. There was one smoking lounge with a TV and one non-smoking lounge with a TV. A newspaper was received every day and kept in the nurses' office and given out on request. Some patients had their own TV in their room. However, there was poor reception and there were no videos on the ward. There was one radio in the nurses station which was piped outside. The mobile library came once a week. A lobby area was pleasantly decorated. The smoking lounge was full of smoke and in bad condition. There were no designated quiet areas and patients sat outside or used their own rooms if they wished to have time out. The nurses' station was central and confidential. There was no observation capacity in the room. There were public phones. There was one telephone in the nurses' station with an extension in the staff room or tea room and one telephone in the dishwasher's room.

There was no examination couch in the clinical room. There was a couch in the staff changing room, which was not used. The unit contained a defibrillator for use in both units and the suction was kept upstairs. Oxygen was available on the trolley. Staff had a toilet-cum-shower area, a changing room and a tea room, which was also used for mentoring the students. The clients' possessions were kept in their own rooms. Many patients managed their own money. The mobile shop came in the evenings and there was also a shop in Unit 8.

UNIT 11

Date of inspection: 21st June 2005

Number of beds: 21

DESCRIPTION

This unit is described as a rehabilitation unit for 21 patients. There is no dedicated multidisciplinary rehabilitation team. There were 15 male patients and six female patients.

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REFERRAL

The only source of referral to this unit is the admission wards within the hospital. Patients are transferred from these wards at the discretion of the consultant psychiatrist.

PROCESS OF ADMISSION

No people under the age of sixteen are admitted to this unit. Patients with a moderate intellectual disability are admitted occasionally. Patients are not admitted for detoxification or for social crisis. On admission to this unit a patient has a full psychiatric assessment carried out by the doctor. The patient is also orientated to the new unit. A physical examination is undertaken on the acute unit and each patient on this unit is subject to a six-monthly review. A collateral history is also taken on the acute unit. On admission, a patient is shown around the ward and is informed of the routine. Family members are notified of the transfer. The Inspectorate was informed that the consultant psychiatrist reviews the patient on a monthly basis, however this was not evident in all the clinical files reviewed. It was also reported the initial treatment plan is documented in the case notes but there were no treatments plans in some of the notes. The patients are allocated key workers on a group basis.

CARE PLAN

The care plans on this unit are nurse-led and the Inspectorate was informed that there was some multidisciplinary team input. This was not evident in the case notes reviewed. Some of the care plans had goals and objectives identified but the majority did not. There was little evidence of any care plans being reviewed although it was reported that they are reviewed every three to six months. Patients are involved in the care planning process. It was reported that the nursing care plans are linked to the Roper Logan Tierney model of nursing. Some of the care plans were reviewed but not all of them.

NURSING PROCESS

The reported model used on this ward is the Roper Logan Tierney model. The Inspectorate was informed

that this does not fully meet with the needs of patients and misses the broad overview. There is no evidence of any risk assessments being carried out. All patients were on general observation and staff wear uniforms.

ACCESS TO THERAPY

Patients can be referred to a psychologist or a social worker. No entries from a social worker or psychologist were in evidence in any of the files reviewed. There is no occupational therapy input to the ward although there are occupational therapists in the recreation centre where the majority of the patients are encouraged to attend. Four consultant psychiatrists have responsibility for patients on this ward. The consultant psychiatrists review the patient on a monthly basis. However there was little evidence to support this in the files and one particular patient had not had anything written about him for over a year. The NCHD is responsible for physical care of patients and carries out a six-monthly assessment.

ACCESS TO THERAPEUTIC PROGRAMMES

Patients on this unit are encouraged to attend the recreation centre. Some groups are run on the ward or on the ward downstairs.

CLINICAL RISK MANAGEMENT

There is a policy on clinical risk management. There is an alarm system in operation and there is also a policy on the use of alcohol, illegal drugs and patients who go missing from the ward. It is not deemed appropriate to have a policy on the management of aggression or rapid tranquillisation. If a patient refuses medication they are reviewed by a doctor. It was stated that it is not appropriate to search patients' belongings or their room. The Inspectorate was also informed that there was no mechanical restraint or physical restraint policy and that there was no restraint used on this unit, although the staff are trained in control and restraint techniques. Staff also receive training in cardio-pulmonary resuscitation and there is an in-house programme of training available to staff. However a

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record of training was not available on the unit as it was held in a central location within the hospital. Serious incidents are recorded on forms, which go to the Assistant Director of Nursing and are reviewed by the Clinical Director. However it was reported that there is no feedback given to the unit. There is an in-house training programme in operation in the hospital. They have the full range of training available, including cardio-pulmonary resuscitation, drugs use in psychiatry, health service developments, and control and restraint.

UNIT MANAGEMENT

Patients are not transferred to other units or to other hospitals due to pressure on beds. There are a few activities available on this ward but most of the patients are encouraged to go to the recreation centre. Patients are given free access to come and go from the ward but are asked to report to nursing staff when they are leaving. The patients are checked at meal times. The door is locked at night for safety reasons. The nursing staff are allocated to this unit by a central roster. New staff are inducted to the unit and given a patient handover. There is no waiting list for this unit. It was reported that one patient is ready to move on to a hostel although the Inspectorate was informed by the management team that a number of patients have been identified for the new hostel when it comes on stream later in the year. Staff on the ward stated that no needs assessments were being carried out on the patients regarding their suitability for the hostel accommodation. There is a need to clarify this situation and for more effective communication. There are set visiting times for this ward but the arrangements are flexible. Meal times are at set intervals and there is availability of drinks and snacks between meals.

SERVICE USER INVOLVEMENT

There was no information available for patients on their treatment or therapy. There did not appear to be any information available to inform people of their rights. Although there is a complaints policy there was nothing displayed within the unit to advertise this. Staff stated that advocacy is available to patients on this ward but they do not ask for it.

RECORDS

Patient's name and ID number was in evidence on the files. The files were legible and were tidy. The entries did not always carry a full name and on occasions there were just initials. In most cases there was no title of personnel used. There was no evidence in the files reviewed of any progress reports from a social worker, occupational therapist or psychologist. The case notes did not always contain a treatment plan. The majority of them contained a six-monthly physical check but contained no further records of any interventions from the medical team. Any interventions that were recorded were following the request from nursing staff to see the patient usually for physical problems.

Nursing files were clear and legible. They had the patient's name and number on all pages and were very tidy. However the interventions recorded seemed to have had no bearing on the care plans that had been identified for the patient. The care plans in a number of files had not been reviewed and were written a number of years ago. The medication sheets were generally very poor. Of the 21 patients on this ward, 15 cards needed rewriting. On some occasions, drugs had been prescribed in 2002 and the cards had not been rewritten.

ENVIRONMENT

This was a 21-bed rehabilitation ward situated in a large psychiatric hospital. There was adequate lighting and ventilation and the décor was adequate. There were no information boards situated on the ward apart from one white board where there was minimal information. There was a visitors' area which was pleasantly furnished but unfortunately this is used as an interview room on occasions, as there were no interview rooms on the unit. All the patients had single bedrooms that contained a bed, sink, wardrobe and cupboard. The décor of these rooms was generally good. There were sufficient numbers of toilets and bathrooms within the unit. Some of the toilets looked dirty and could have done with modernising. There was free access to the toilets and bathrooms. They were gender specific and there were overriding locks on the doors. The dining area was sufficient for one sitting and was situated on the ward downstairs. The lounge areas were reasonably

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comfortable and the décor was fine. The nursing station was situated in a central corridor. It appeared to be confidential. There was sufficient space for report writing and it was accessible. There was phone access but no IT. The clinic room was also situated on the main corridor. There was sufficient medical equipment and cardio-pulmonary resuscitation equipment and this was checked weekly. There was adequate storage within this unit. All patients had individual wardrobes and there was a central store as well. Patients' money was handled by accounts in the general office and €50 was sent each week to the ward and the patients sign for their money.

NORTH CORK

SOLAS NUA, MALLOW

Date of inspection: 23rd June 2005

Number of beds: 14

DESCRIPTION

Solas Nua is a 14-bed 24-hour high support social housing residence for six male residents and eight female residents. The residence opened in 1999 and is situated close to town. The residence serves the population of North Cork.

REFERRAL

St. Stephen's Hospital in Glanmire is the main source of referral, usually Unit 10. The consultant psychiatrist with responsibility for the residence processes any referral. There is an assessment carried out on the host ward usually by an occupational therapist and the consultant psychiatrist. The residence staff have the opportunity to assess the patient prior to transfer. It was also pointed out that the residents visit the residence prior to transfer.

PROCESS OF ADMISSION

On admission to the residence, the residents are introduced to staff and fellow residents. They are helped to settle in and are advised of the rules of the unit. One of the criteria for admission is that a person

must reside in North Cork and have a history of mental illness. The only exclusion criterion is a history of recent violence. There is a rehabilitation programme in place in the residence. The residence is not used as an alternative to acute admission or for respite care. People do not come to the residence for detoxification or for social crisis. Prior to admission to the residence, there is a case conference and family members are involved in this. On admission to the residence, one of the nurses is assigned as a key worker and carries out a full assessment. Within the first week of admission a resident registers with a local GP who carries out a physical examination. Collateral history has been previously taken within the hospital. The decision to transfer somebody to this residence is a team decision. Although the consultant carries out the majority of the assessments, the nursing staff also have input into the decision to admit a resident to the residence. It appears there was a lot of work carried out, prior to transfer, in obtaining patients' views in the hospital and explaining how the care plan system works. Family members are notified and the residence staff try to keep the family involved as much as possible. The consultant psychiatrist reviews the patient within the first month and the initial treatment plan is documented in the notes.

CARE PLAN

There is a system in place in the residence called Individual Planned Processing (IPP). Each resident has an occupational therapy assessment, a psychology assessment and a nursing assessment. Needs are identified at a case conference prior to transfer and a full social functioning questionnaire is completed by the nurse on admission. The patient is involved during interviews and one-to-one sessions. Goals and objectives are identified and prioritised and a key worker is identified. Care plans are then instigated following this period of assessment. These care plans are reviewed between one and three months later and then every six months. Some residents have signed their care plans. At the present time there is no formal policy on the discharge of a resident from the residence. There are links with Norwood, a day centre in the area, and with the voluntary sector. Last year only one person was discharged from the residence. Three were discharged in 2003. The Cork Mental Health Association has purchased a house in

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Mallow, Bachelors Walk and there are four independent beds there. This is where people tend to move on to from Solas Nua. It was identified that five people could move to a new residence that is being built in Kanturk. However, a number of these people stated they don't want to move because they are happy in the residence in Mallow. Currently there is one female resident who is appropriate for moving on to a lower level of support accommodation.

NURSING PROCESS

The staff in the residence have identified part of the Tidal model as the appropriate model to use in the residence. They also carry out a social questionnaire. It is felt this is appropriate to the needs of the residents and leads to the implementation of the IPP plan. It does contain a risk assessment.

REHABILITATION TEAM

There is no rehabilitation team in the area. There are regular sessions provided by occupational therapy. There is only one social worker covering the whole area of North Cork. Access to the social worker is very limited. There is a referral system to a clinical psychologist. There is one consultant psychiatrist who has overall responsibility for the residence and it was reported that he provides a very good service to the residence. The consultant psychiatrist reviews each resident between three and six months. All the residents are registered with a local GP and have the full range of primary care available to them. There are eight nursing staff in total working within the residence and there are usually two on duty throughout the day and a nurse and an attendant on during the night.

INVOLVEMENT IN REHABILITATION PROGRAMMES

Each resident is involved in their IPP plan. The ethos is to try and promote as independent a life as possible for the residents. Residents attend a number of services off site. Initially they are accompanied by a member of staff and then they go unaccompanied.

CLINICAL RISK MANAGEMENT

There is a policy available on risk management. There is no alarm system in operation as this was not deemed to be appropriate. There are policies on alcohol, illegal drugs, persons missing from the unit, searching residents and searching residents' rooms or bed area. All serious untoward incidents are recorded on forms and sent to St. Stephen's Hospital senior management.

UNIT MANAGEMENT

There are no temporary transfers or long-term transfers to other units. The skill mix within the residence is predominantly qualified nurses although there are attendants, especially at night. The unit has its own staff but there is some central rostering to cover annual leave. There are two household staff present during the day. All residents and staff have a formal induction to the residence which covers orientation, familiarisation, introduction to staff and other residents and general housekeeping rules and policies. At the moment there is only verbal feedback from the residents and family members to say whether people were happy with the service. There is pressure on the service to accept referrals. The waiting list is managed by the sector teams. Maintenance is carried out within the residence by the Cork Mental Health Association and this is reported to be working well. The household staff are employed by the HSE.

HOUSE RULES

A small booklet is given to each resident and their family member on their transfer to the residence, describing the general philosophy and principles of the residence. It is reviewed on an ongoing basis. The visiting times to the residence are flexible. Residents do not have a front door key but the door is open most of the time. All residents have en-suite single bedrooms, which can be locked. Residents are allowed to leave the residence unsupervised but are asked to check with nursing staff when they are going in and out of the building. They are not required to be out during the day, it is personal choice. Meals are prepared within the residence by an attendant and the residents are involved in the

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process of cooking meals. It is reported that the residents are involved in planning and shopping for the ingredients. Residents have free access to the kitchen and are encouraged to make drinks and snacks in between meals. There are no set rules regarding the times of going to bed and getting up in the morning. Residents are not allowed to smoke in the bedrooms. There are designated smoking areas. It was stated there were no facilities for visitors to stay overnight. All residents have their own bank accounts. There is a policy on financial management of residents' money and all residents hold a bank card. It is reported that all residents have independent access to their money as required. For four of the older residents, the money is collected by staff and signed for by these residents. Residents' benefits are paid into their own bank accounts and a standing order is made to the residence to cover household goods, rent and provisions. Residents can purchase their own furniture if they require but the HSE provides all the furniture and fittings within the residence. Residents buy their own clothes in local shops and have free access to use the laundry facilities. The residence is well integrated in the local community. The residents access the local shop and town and there is a very good relationship with the staff there. Residents also go to a day centre. There are various outings and one of the male residents is a member of a local choir. All the local facilities are within walking distance and there is a bus available but residents are encouraged to use public transport.

SERVICE USER INVOLVEMENT

There is information on treatment for the residents as well as information on their rights. All residents have the availability to vote and some choose to do so. There is availability of information on national health issues. There is a complaints policy and verbal complaints are dealt with on site. Any written complaints go to hospital management. There are regular meetings to ascertain residents' opinions on issues such as menu planning and what activities are being planned. Carers' views are sought on visits and this is done verbally. There is access to advocacy services.

RECORDS

Residents can access their file but do not write in them. Files were legible and tidy and contained the names and ID numbers. There is a signature bank available and entries are signed and dated and have full names and titles of personnel. Within the notes there are regular entries from occupational therapy, nursing and medical staff. They contain treatment plans. The consultant psychiatrist reviews each resident every three to six months and the NCHD visits when requested. Nursing files contain the IPP and are legible and tidy and all entries are signed and dated. All the drugs are prescribed by the local GP and dispensed by a local pharmacist. There is a self-medication programme within the residence, which is split into three stages. There is no central storage of drugs within the residence. All the residents have access to a locked drawer within their rooms and drugs are kept here if the resident is self-medicating.

ENVIRONMENT

There is a regular ongoing maintenance programme in place with the Cork Mental Health Association. The hygiene and décor of the residence is excellent. The residence appears to have comfortable furniture. All the bedrooms are en-suite and provide high levels of safety, privacy and dignity. There is plenty of personal storage.

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WEST CORK RECOMMENDATIONS**ACUTE UNIT, GENERAL HOSPITAL, BANTRY**

1. The unit is too small to accommodate an acute psychiatric unit for 18 patients. There is no lift between the floors, which results in restricted access for patients. Alternative accommodation should be sought which incorporates a high observation area.
2. Agreement must be attained regarding the current situation between West Cork and Carraig Mór that ensures a consistent and safe procedure for the assessment and transfer of patients.
3. All patients must have a psychiatric and physical assessment on admission to the acute admission unit.
4. Beds of patients on leave should not be used for newly admitted patients.
5. All written interventions and prescriptions must be dated and have legible signatures with the name and designation of the clinician clearly printed.
6. The vacant psychology post should be filled as soon as possible.

COMMUNITY RESIDENCES**ARDRÉALT HOUSE**

1. There should be formal measures to ascertain residents' satisfaction and their views on the service.
2. All written interventions and prescriptions must be dated and have legible signatures with the name and designation of the clinician clearly printed.

PERROTT HOUSE

1. Each resident should have an integrated care and treatment plan that contains a social,

psychological, occupational, nursing, psychiatric and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the 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 resident has been involved in developing his or her care plan, and the resident must have a copy of the care plan. The care plan must be coordinated by the resident's key worker.

2. The residents should be accommodated in smaller residences according to their assessed need.

ELMWOOD HOUSE

1. Each resident should have their own bank or post office account. Each resident should have a copy of their own financial statements and should manage their own money as far as possible.

SOUTH LEE**GROUND FLOOR ACUTE UNIT, CORK UNIVERSITY HOSPITAL**

1. There should be a full multidisciplinary team in each sector. Each patient should have access to a psychologist, occupational therapist and social worker as well as other disciplines where necessary. There should be occupational therapy input into 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 must be documented evidence that the patient

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

3. There should be a high observation area in the unit to provide a safe therapeutic environment for patients where necessary.
4. The clozapine clinic should be held elsewhere to relieve the congestion and movement of people in and out of the ward.
5. The unit is unsuitable as an acute admission unit due its size, layout and the fact that it is a two-storey building. There is insufficient office and assessment space. The service requires a purpose-built admission unit.
6. There should be no unsupervised access to the upstairs sleeping area.

ST FINBARR'S HOSPITAL, CORK

ST. MONICA'S WARD

1. Each patient should have an integrated care and treatment plan that contains a social, psychological, occupational, nursing, psychiatric and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated by the patient's key worker.
2. All patients should have regular psychiatric and physical reviews.
3. The unit is unsuitable for patients. New accommodation should be provided which meets the needs of this elderly group of patients.

ST CATHERINE'S WARD

1. All patients have been assessed as to their accommodation needs and accommodation is required to enable patients to move to the community.
2. There should a multidisciplinary rehabilitation team within the service with responsibility for this ward.
3. Patients from the acute unit should not sleep in St. Catherine's Ward because of bed shortages in the acute unit.
4. The ward should be self-staffing to ensure an effective key worker system.

COMMUNITY RESIDENCES

GLENMALURE HOUSE

1. There should a multidisciplinary rehabilitation team within the service with responsibility for this community residence.

NORTH LEE

ST MICHAEL'S UNIT, MERCY HOSPITAL

1. People under the age of 16 should not be admitted to this unit.
2. The numbers of psychologists, occupational therapists and social workers should be increased to ensure that each sector has a core multidisciplinary team.
3. The policy on nursing people in their night attire should be reviewed.
4. Staff should be trained in restraint techniques that are consistent throughout the unit.
5. Policies should be implemented regarding clinical risk management and searching patients and their belongings.
6. Appropriate signage should be displayed advertising the use of CCTV.

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7. Each patient should be assessed for their future accommodation needs and appropriate resources provided.
8. The unit should have access to a ward clerk.

CARRAIG MÓR, SHANKIEL

1. There should be a clear admission policy for this unit. Agreement must be attained regarding the current situation between West Cork and Carraig Mór that ensures a consistent and safe procedure for the assessment and transfer of patients.
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.
3. Each patient should be assessed for their future accommodation needs and appropriate resources provided.
4. Policies should be implemented regarding clinical risk assessment and management.
5. Appropriate signage should be displayed advertising the use of CCTV.
6. The unit should have access to a ward clerk.
7. All written interventions and prescriptions must be dated, have a legible signature with the name and designation of the clinician clearly printed.
8. Induction for all staff should be formalised.

OWENACURRA

1. There should be a clear admission 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 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. Patients' must have regular physical and mental state examinations and these should be recorded in their clinical file.

NORTH LEE COMMUNITY RESIDENCES**OVERALL RECOMMENDATIONS**

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

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4. There should be a structure in place for obtaining residents' and carers' views and feedback about the service.
5. Residents' must have regular physical and mental state examinations and these should be recorded in their clinical file.
6. Nursing models must be introduced to the units and should be regularly reviewed to ensure that the assessed needs of the resident are being met.
7. Residents should be involved in all aspects of their care.
8. Residents must receive in writing any changes in relation to paying rent.

MILLFIELD HOUSE

1. Consideration should be given to the practice of residents having to be out of the hostel during the day. If this is the case, then staff should be deployed to stay with the residents rather than staying in an empty house.
2. There should be ongoing training for staff designed to meet the needs of the residents.

GOUGANE BARRA HOUSE

1. Consideration should be made to respect the safety, privacy and dignity of the residents balanced with the risk they may pose in relation to allowing residents to lock their bedroom door.
2. Essential maintenance work should be carried out as a matter of urgency and a maintenance programme put in place.

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ST STEPHEN'S HOSPITAL

OVERALL RECOMMENDATIONS

1. Each patient should have an integrated care and treatment plan that contains a social, psychological, occupational, nursing, psychiatric and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated by the patient's key worker.
2. The nursing models in use should be regularly reviewed to ensure that the assessed needs of the patient are being met.
3. The units should be self-staffing to ensure continuity of care.
4. There should be a structure in place for obtaining patients' and carers' views and feedback about the service.
5. All written interventions and prescriptions must be dated, have a legible signature with the name and designation of the clinician clearly printed.
6. A multidisciplinary rehabilitation team should be introduced within the service.
7. Each resident should be assessed for their future accommodation needs and appropriate resources provided.
8. There should be ward-based therapeutic activities, based on need for patients unable to leave the units.
9. Residents must have regular physical and mental state examinations and these should be recorded in the patients' clinical file.

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10. The number of psychologists, occupational therapists and social workers should be increased to ensure that each sector has a core multidisciplinary team.
11. All clinical policies should be reviewed and implemented.

UNIT 1

1. Medical cover needs to be clarified and the views of the staff incorporated into the arrangements.

UNIT 2

1. There is a need for occupational therapy input on the unit.
2. There must be clear documentation in the patients' files as to the reasons they are detained in hospital.
3. Essential maintenance work should be carried out as a matter of urgency and a maintenance programme put in place.

UNIT 3 (FEMALE ACUTE UNIT)

1. The ECT facilities must be upgraded to ensure the safe delivery of treatment in an environment that promotes the patients safety, privacy and dignity.
2. Patients should not sleep in other units due to bed shortages.
3. Male patients should not be transferred to this unit if the patients' safety, privacy and dignity cannot be maintained.
4. All decisions to admit a patient should be discussed with a consultant psychiatrist.

UNIT 4 (MALE ACUTE UNIT)

1. The policy on nursing people in their night attire should be reviewed.
2. All decisions to admit a patient should be discussed with a consultant psychiatrist.
3. Patients should not sleep in other units due to bed shortages.

UNIT 5

1. People with a learning disability should be moved to a service where there needs can be more appropriately met.

UNIT 8 (SECOND FLOOR)

1. Consideration should be given for this unit to come under the care of the Psychiatry of Later Life service.
2. There should be an admission policy in place.
3. The asbestos in the ceiling must be removed.

UNIT 8 (THIRD FLOOR)

1. Essential maintenance work should be carried out as a matter of urgency and a maintenance programme put in place.

UNIT 10

1. The alarms must be repaired and regularly checked.
2. The current situation with shared access to the toilets and bathrooms needs to be resolved and any refurbishment undertaken.

Kerry and Cork

UNIT 11

1. The unit staff must to be kept informed of any developments to move patients from this unit and be involved in any patient assessments.
2. Essential maintenance work should be carried out as a matter of urgency and a maintenance programme put in place.

SOLAS NUA COMMUNITY RESIDENCE

1. A policy on discharge should be implemented.
2. All residents must be kept informed of any plans to move them to a new facility.
3. A multidisciplinary rehabilitation team should be introduced within the service.
4. Each resident should be assessed for their future accommodation needs and appropriate resources provided.
5. The number of psychologists, occupational therapists and social workers should be increased to ensure that each sector has a core multidisciplinary team.
6. There should be a structure in place for obtaining patients' and carers' views and feedback about the service.

KERRY RECOMMENDATIONS

ACUTE UNIT-TRALEE

1. Each patient should have an integrated care and treatment plan that contains a social, psychological, occupational, nursing, psychiatric and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated by the patient's key worker.
2. The policy on nursing people in their night attire should be reviewed.
3. The activity programme should be needs-based and linked to the patients care plans.
4. The unit should be self-staffing to ensure continuity of care.
5. All written interventions and prescriptions must be dated, have a legible signature with the name and designation of the clinician clearly printed.
6. The safety issues regarding the seclusion rooms must be addressed.
7. All decisions to admit a patient must be made in consultation with a consultant psychiatrist. The admissions for the sole purpose of detoxification should cease.

ST FINAN'S HOSPITAL, KILLARNEY**OVERALL RECOMMENDATIONS**

1. Each patient should have an integrated care and treatment plan that contains a social, psychological, occupational, nursing, psychiatric and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated by the patient's key worker.
2. Nursing models must be introduced to the units and should be regularly reviewed to ensure that the assessed needs of the patient are being met.
3. Each resident should be assessed for their future accommodation needs and appropriate resources provided.
4. There should be a policy on risk management, incorporating training for staff and debriefings following serious incidents.
5. All written interventions and prescriptions must be dated, have a legible signature with the name and designation of the clinician clearly printed.
6. There should be a structure in place for obtaining patients' and carers' views and feedback about the service.
7. Patients' must have regular physical and mental state examinations and these should be recorded in the patients' clinical file.
8. Adequate funding and resources must be made available to ensure staff are appropriately trained to meet the needs of the patients.
9. The units should be self-staffing to ensure continuity of care.
10. Activity programmes should be implemented that are needs-based and linked to the patients care plans.
11. All residents must have access to individual bank accounts and the practice of "pooling" patients' money must cease.

ST PETER'S WARD

1. A system for ensuring adequate ventilation in the seclusion room must be installed.
2. Essential maintenance work should be carried out as a matter of urgency and a maintenance programme put in place.
3. Consideration should be made to respect the privacy and dignity of the patients balanced with the risk they may pose.

ST MARTIN'S WARD

1. The practice of locking patients in their rooms at night must cease and appropriate risk assessments and resources must be made available to ensure the safety of the ward.
2. The policy on nursing people in their night attire should be reviewed.

OUR LADY'S WARD

1. All patients should have a seating assessment undertaken and appropriate seats purchased.
2. If any mechanical restraint is required this must be individually prescribed, documented in the patient's chart and regularly reviewed.
3. The issue regarding wheelchair accessibility must be addressed.

Kerry and Cork

ST PAUL'S WARD

1. Patients' must be made aware of their rights pertaining to the 1945 Mental Treatment Act.

O'CONNOR UNIT (WEST WING)

1. Essential maintenance work should be carried out as a matter of urgency and a maintenance programme put in place.
2. The safety and privacy issues must be addressed.
3. Policies should be implemented regarding the use of alcohol or illegal drugs and giving medication without consent.

O'CONNOR UNIT (EAST WING)

1. Patients who undertake employment should receive at least the minimum wage.
2. Policies should be implemented regarding the use of alcohol/illegal drugs and giving medication without consent.

COMMUNITY RESIDENCES**OVERALL RECOMMENDATIONS**

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

2. All community residences should have an admission policy which clearly states what their function is and who is appropriate for admission.
3. A multidisciplinary rehabilitation team should be introduced within the service.
4. Each resident should be assessed for their future accommodation needs and appropriate resources provided.
5. There should be a structure in place for obtaining residents' and carers' views and feedback about the service.
6. Residents' must have regular physical and mental state examinations and these should be recorded in their clinical file.
7. Adequate funding and resources must be made available to ensure staff are appropriately trained to meet the needs of the residents.
8. The units should be self-staffing to ensure continuity of care.
9. Activity programmes should be implemented that are needs based and linked to the residents care plans.
10. All written interventions and prescriptions must be dated, have a legible signature with the name and designation of the clinician clearly printed.

WRITER'S GROVE

1. Essential maintenance work should be carried out as a matter of urgency and a maintenance programme put in place.

KILLARDEN HOUSE

1. Consideration should be made to respect the safety, privacy and dignity of the residents balanced with the risk they may pose in relation to allowing residents to lock their bedroom door.

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Kerry and Cork

ISLAND VIEW

1. Essential maintenance work should be carried out as a matter of urgency and a maintenance programme put in place. Consideration must be made into extending the premises to eradicate the issues of overcrowding.

CHERRYFIELD HOUSE

1. Essential maintenance work should be carried out as a matter of urgency and a maintenance programme put in place.

BRIDGE VIEW AND ARCHVIEW

1. The issues in relation to the numbers of staff on duty must be resolved to ensure that the residents are cared for in a safe environment with appropriately trained staff.
2. Essential maintenance work should be carried out as a matter of urgency and a maintenance programme put in place and more robust and appropriate furniture purchased.

TEACH AN CHÚRAM

1. Essential maintenance work should be carried out as a matter of urgency and a maintenance programme put in place.

Chapter 2

Health Service Executive
Wexford, Waterford, South Tipperary and
Kilkenny/Carlow

Wexford, Waterford, South Tipperary and Kilkenny/Carlow

ST. SENAN'S HOSPITAL

ST. AIDAN'S WARD

Date of inspection: 7th September 2005

Number of beds: 16 male

DESCRIPTION

St. Aidan's ward is located in St. Senan's Hospital. Its function is in care of elderly patients and is under the responsibility of the consultant for Psychiatry of Later Life (POLL). There is also one patient from the rehabilitation programme on the ward. All patients have severe cognitive impairment and some have severe challenging behaviour. The age range is from 52 to 85 years.

REFERRAL AND PROCESS OF ADMISSION

Patients are admitted from the elderly admission ward. Patients have also been admitted from the male admission ward. Fifty per cent of the patients have been long-stay in the hospital. All patients are assessed before admission to the ward.

CARE PLAN

There is no multidisciplinary care plan but there is a nursing care plan. The consultant psychiatrist attends the ward weekly and there is a team meeting once a week. There are no discharges from this ward apart from very occasional discharges to nursing homes.

NURSING PROCESS

The Orem Peplau nursing model is in use on the unit. Staff feel that this is not fully appropriate to the needs of this patient group. There is general observation on the ward. There is no key worker or primary nurse system. There is some continuity of nursing staff through the central rostering system.

ACCESS TO THERAPY

There is no input from a psychologist or social worker to the ward. There is no occupational therapist in the service. There are no visiting therapists such as art or music therapists. There is pastoral care available. There are some difficulties in patients attending medical or surgical appointments due to lack of staff and on occasion appointments have been cancelled. Occasionally there are also transport problems.

ACCESS TO THERAPEUTIC PROGRAMMES

There are no activities on the ward. There is access to a snoezelen room but low staffing numbers make this difficult to access.

SECLUSION

Seclusion is not carried out on this ward.

CLINICAL RISK MANAGEMENT

All policies were available on the unit. All staff have been trained in control and restraint techniques, breakaway techniques and cardio-pulmonary resuscitation, and have received refresher courses. A pinpoint alarm system was in operation on the ward. Mechanical restraint is not used on the ward and patients are not belted into chairs. Serious incidents are reported using a standardised form. Debriefing is available after a serious incident if required.

UNIT MANAGEMENT

There are no transfers of patients to or from the ward because of bed shortages. There are three nursing staff on the ward during the day and one staff nurse at night. There is one household staff on duty during the day. There is no CCTV on the ward. Nursing staff perform phlebotomy services. There is no waiting list for the ward. Meal times are at the usual times. Bedtimes are between 1700h and 2300h. Visiting times are flexible.

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SERVICE USER INVOLVEMENT

There are information leaflets available for the patients. There is no formal carers support available.

RECORDS

The clinical records were reasonably tidy. The signatures were illegible in some cases and no title of personnel was given in some clinical files. This made it difficult to identify consultant psychiatrist reviews. The patients all had six-monthly physical examinations. Nursing care plans were satisfactory.

ENVIRONMENT

This is a 116-bed compact ward situated on the ground floor of a mental health hospital. A maintenance programme is ongoing. There was disabled access and appropriate lighting and ventilation. The décor was of satisfactory standard. The corridors had recently been refurbished. There were information boards available but unfortunately a number of the items placed on the information board are removed by patients. There was a dedicated visitors' area and access to a sensory room. The bedroom areas offered privacy. There were two single bedrooms and two dormitories, one with five beds and one with nine beds. There were curtains around the bed areas. Each patient had their own wardrobe space and had their own clothes. The décor was of a good standard. The toilets and bathrooms were of a satisfactory standard and people were generally accompanied to the toilet. This was an all-male unit. There were specific bathing times and there were overriding locks on the doors. It was reported that the shower room needed renovating and had recently been measured and costed for this process. The dining area doubled as a lounge area. There was space for all patients at one sitting but all the patients require feeding. The lounge component of this room had comfortable seating and a TV. It was reasonably well decorated. The nurses' station was situated centrally between the two dormitories. There was space for report writing. It was accessible and there was a telephone system but no IT. There was an alarm system. The office also contained cardio-pulmonary resuscitation equipment, oxygen, suction and all the medication.

There was storage within the unit for patients' possessions. There was no money on the unit as patients have credit with the hospital shop. Files and records were safely stored as was medication.

ST. ANNE'S WARD

Date of inspection: 7th September 2005

Number of beds: 13 female

DESCRIPTION

This is a female acute admission ward with 13 beds. On the day of inspection, there were 16 people occupying beds, six of whom were detained. The ward is described as locked.

REFERRAL

The source of referral to this ward is outpatient clinics, Wexford General Hospital, GPs and self-referrals. Referrals are made to the ward and an assessment is organised. The NCHD assesses the referral on the ward and makes the decision whether or not to admit the patient. All admissions from outpatients and the consultation liaison service to Wexford General Hospital are by prior agreement with the appropriate consultant psychiatrist.

PROCESS OF ADMISSION

There is an admission policy in existence with which staff were familiar. Children under the age of 16 or people with a moderate intellectual disability are not admitted to the ward. People are frequently admitted for detoxification. Once the decision to admit the patient is made, the NCHD carries out a mental state examination, a physical examination and obtain a collateral history. The consultant psychiatrist is routinely involved in all decisions to admit patients. The patient's GP is not routinely informed of the admission. Part of the admission process is to explain to the patient why they are being admitted and this is done where possible. Communication with the family is also undertaken. The patient is reviewed by a consultant psychiatrist within 24 hours and the initial treatment plan is documented in the case

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notes. Patients are rarely placed in their night clothes as part of the admission procedure. The observation levels are decided by the NCHD and the patient may be placed on one-to-one nursing or have periodic checks. There is a key worker system that involves staff being allocated to sectors and allocated to patients from that sector.

CARE PLAN

Care plans are nurse based. They identify the nursing needs and a referral is made to any other discipline if felt appropriate. There are goals and objectives identified and a key worker is responsible for reviewing the care plans which is done on a weekly basis. The patients do not sign the care plans.

There is a discharge process and the team identify when a patient is ready to leave the ward. There is a gradual leave process leading up to eventual discharge. All relevant parties are informed when a patient is discharged.

NURSING PROCESS

The nursing staff use the Peplau/Orem model of nursing. This is described as appropriate to needs and is implemented by the key worker. There is no formal risk assessment tool used with the model.

ACCESS TO THERAPY

There is an activation ward within the hospital that patients can access when their mental state allows. The centre is run by nursing staff. There is no occupational therapy available to the ward. There is a referral system to a psychologist and social worker which is described as satisfactory. The sector addiction counsellors are available to the ward. The ward is also piloting a self-harm project. There are sector consultant psychiatrists, the POLL psychiatrist and the rehabilitation psychiatrist have access to beds and they review patients twice a week. The NCHD is available on a daily basis and will look after patients' physical well-being or arrange for transfer to the general hospital.

ACCESS TO THERAPEUTIC PROGRAMMES

Staff reported that there are some informal groups occurring on the ward but when people are well enough they attend the activation ward. Group facilitation programmes take place for the inpatients.

ECT

There is an ECT policy and procedure in place. Consent for ECT is obtained by the consultant psychiatrist. There is a written information pack for the patients. Each session is recorded. There is a dedicated ECT nurse who is rostered from the two acute wards and the "step down" wards. It was reported that this member of staff is included in the complement of nursing staff allocated to the ward. There is a dedicated ECT consultant.

SECLUSION

There is a seclusion policy and register. The seclusion room is clean, safe, well ventilated with natural light. There is an observation panel in the door and communication facility with the patient. There are no toilets. The patient has to be escorted to the toilet or use a commode. Staff reported they only use refractory clothing if a patient exhibits severe attempts at self-harm.

CLINICAL RISK MANAGEMENT

There is a comprehensive policy followed within the ward. All staff must sign to say that they have read the policies. There is a new policy on rapid tranquillisation following last year's inspection. The staff receive training in control and restraint techniques which incorporates de-escalation and breakaway techniques. They also undertake other mandatory training such as cardio-pulmonary resuscitation and manual handling. There are no clinical risk assessments documented in the patients' charts and this was identified as a training need. Serious incidents are reported on the appropriate forms which are sent to the assistant chief nursing officer and the Director of Nursing. Feedback is given to the ward on incidents. There is also debriefing available after a serious incident. There is access to

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degree and diploma courses and staff are facilitated to attend these courses, subject to the needs of the service. It was reported that on occasions staff have to use leave or change shifts to access these courses. There is partial funding but most courses are in Dublin and involve travelling.

UNIT MANAGEMENT

Patients frequently sleep out to other wards within the hospital and patients are identified to sleep out during the day if there are more than thirteen people on the ward. The staff ascertain where a bed is available within the hospital, usually on the pre-discharge ward or St. Gertrude's Ward. The patient is transferred overnight to the ward and returns the following day. It was reported that there is increasing pressure on use of the acute beds and currently there are five people over 80 years within St. Anne's Ward. Patients are allowed off the ward at the discretion of the consultant psychiatrist. The door is always locked. The ward is not used for other purposes although it was noted that the corridor through the wards is used to gain access to other wards and is frequently used.

There are four qualified nursing staff on duty during the day. It was reported that if a patient was on one-to-one observation no extra staff are allocated to the ward. If there is more than one then an extra nurse is rostered. There are two qualified nurses on duty at night. The ward is staffed through a central rostering system although there are some core staff. It was reported that St. Anne's ward are going to pilot a self-staffing system in the near future. There is one household member of staff on duty during the day and it was reported that more are needed. There is also no administrative support and the ward needs a ward clerk.

Maintenance is carried out by the maintenance team within the hospital and it was observed that the ward recently had been rewired and therefore needs repainting. The dormitory areas also require new curtains and duvet covers. Visiting times are flexible but people are asked to avoid meal times. There are set times for meals and drinks are provided during the day.

SERVICE USER INVOLVEMENT

There is information on treatment therapies and patients' rights. There is a complaints procedure which is advertised within the ward. Carers' views are requested on visits and through phone calls.

RECORDS

The ward used a single case note system. Patients' name and ID number was on all the pages and they were legible. The files were tidy and well kept. All entries were signed and dated and contained progress reports from allied health professionals. There was a treatment plan which was signed and dated and progress reports. Consultant psychiatrists review the patients twice a week and the NCHD is available daily. The nursing care plans were up to date and regularly reviewed. The drug card index was signed, dated, legible and generic names were used. The charts of patients who had been secluded, restrained or involuntarily admitted were reviewed and were all satisfactory.

ENVIRONMENT

This was a 13-bed acute ward on the ground floor of a mental health hospital. There was a maintenance programme and disabled access. Lighting and ventilation was satisfactory. The décor of the ward needed updating after the rewiring. The main corridor through the ward was a thoroughfare to other wards. There was no dedicated visitors' area. There was access to a garden. The admission area was part of the main corridor of the ward. There was an office dedicated for the process of admissions which had an observation panel in the door and an alarm. The bed areas were all dormitories. There were no single rooms. The dormitories were either 4-bed or 9-bed. It was reported that new curtains and duvets were needed for the dormitory areas. There was individual wardrobe space. The dormitories required repainting. Toilets and bathrooms were of a reasonable standard but there was evidence of damp in the shower room. It was reported that the showers work well. There was free access and there were overriding locks. The dining area was cramped during the day due to the high numbers. It was integrated and the décor was of a good standard. There was no

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dedicated exercise or activity area on the ward. The lounge area contained comfortable seating and there was access to newspapers, TV and books. There was no dedicated quiet area. There were two interview rooms available which were soundproof and were situated at the end of the corridor or in the middle of the corridor. There were observation panels and alarms in both rooms. The nurses' station was central and contained space for report writing. It was accessible and had a telephone and IT system. The clinical room had appropriate equipment and storage. It was reported that the emergency response trolley was situated on St. Anne's Ward on a permanent basis and it was queried by staff whether this could be done on a rota basis with other wards. The seclusion room was situated on the main corridor. The windows were appropriately covered and there was plenty of natural light. There was an observation panel in the door that opened outwards. It was of adequate width and appeared to be solid. There was a high mattress within the room. Decor, lighting and ventilation were of a good standard. There was a seclusion policy. The seclusion register was inspected and was satisfactory.

ST. BRENDAN'S WARD

Date of inspection: 8th September 2005

Number of beds: 12 female, 2 male

DESCRIPTION

St. Brendan's Ward is located on the ground floor of St. Senan's Hospital. It is a locked unit. All patients have intellectual disability and some patients have severe challenging behaviour. A number of patients are also incontinent. Seven patients attend a day care unit in Gorey on a daily basis. Funding has been obtained for five patients to be relocated to Gorey in a specialised centre next to the day care centre. There are plans for 24-hour supervised accommodation for seven other patients. One patient requires specialist care and funding has been allocated to obtain this service in the United Kingdom. It is planned to close the ward within the next two years.

REFERRAL AND PROCESS OF ADMISSION

No patients are admitted to the ward as it is planned to close the ward as soon as possible.

CARE PLAN

There is no multidisciplinary care plan. There is a nursing care plan. The consultant psychiatrist attends the ward weekly and meets with nursing staff but there are no scheduled team meetings.

NURSING PROCESS

The Orem Peplau nursing model is in use on the unit. Staff feel that this is not completely appropriate to the needs of this patient group. There is general observation on the ward. At present approximately 50% of nursing time is taken with supervising one patient with severe behavioural difficulties.

ACCESS TO THERAPY

There is no social worker input to the ward. One patient is currently accessing psychology services. There is no occupational therapist in the service. Access to medical and surgical assessments and treatment can be prioritised if necessary. The consultant psychiatrist attends the ward once a week. There are no multidisciplinary team meetings.

ACCESS TO THERAPEUTIC PROGRAMMES

Some patients go to an activation unit and a day care centre. Nursing staff provide a large number of activities in the form of jigsaws, educational games, walks, painting and ball games. There is also access to a snoezelen room but low staffing numbers make this difficult to access.

SECLUSION

Seclusion is carried out on this ward and is used as part of a behavioural programme with one patient. This patient also sleeps in the locked seclusion room

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at night. There is an up-to-date seclusion register and 15-minute observation checklist. There is also a seclusion policy and seclusion episodes were written in the clinical file. The seclusion room was clean with specialised a safety bed. The window was safe and there was a panel on the door. There was ventilation and a clock on the wall. There was also patient's artwork out of reach on the wall. The walls had a hard surface.

CLINICAL RISK MANAGEMENT

All policies were available on the unit. A pinpoint alarm system was in operation on the ward. Mechanical restraint is not used on this ward. Serious incidents are reported using a standardised form. Debriefing is available after a serious incident if required. All staff have been trained in control and restraint techniques, breakaway techniques and cardio-pulmonary resuscitation, and receive refresher courses.

UNIT MANAGEMENT

There are no transfers of patients to or from the ward because of bed shortages. There are three nursing staff on the ward in the daytime and one staff nurse on duty at night. There is one household staff on duty during the day. There is no CCTV on the ward. There is no waiting list and all patients are awaiting alternative accommodation. Meal times are at the usual times. Every patient has a daily shower even though there was only one shower. The nurses' office was very small and, due to its size, did not contain a desk. The clinic room was also very small. The toilet areas required painting and replacement of toilet seats.

SERVICE USER INVOLVEMENT

Due to the serious and profound levels of disability and behaviour there are no information leaflets available on the ward for the patients. Information is available for relatives by request. There is no formal carers support available.

RECORDS

The clinical records were reasonably tidy. The signatures were illegible in some cases and no title of personnel was given in some clinical files. The medication sheets were legible. Nursing care plans were satisfactory.

ENVIRONMENT

The excellent efforts by nursing staff to make this ward as stimulating as possible were obvious. The ward was brightly decorated and contained a large amount of sensory equipment and decoration. The two male patients on the ward shared a double bedroom which had two wardrobes and personal items. There were four single rooms and a dormitory for the female patients. All the single rooms were personalised. The dormitory was cheerful, with art work on the windows and walls. It was open and patients could access their own areas. There was a day room combined with a dining area. This was bright, with sensory equipment, TV, music centre, games and comfortable seating. There was a small garden area that was part of a car park but patients could sit in this area.

ST. BRIDGET'S WARD

Date of inspection: 7th September 2005

Number of beds: 8

DESCRIPTION

This ward is located on the first floor. It has recently been reorganised and accepts male elderly acute admissions. All consultant psychiatrists have admitting rights to the ward, one of who is a consultant psychiatrist in Psychiatry of Later Life (POLL).

REFERRAL

All referrals come through the consultant psychiatrist. The POLL team completes a domiciliary visit prior to admission.

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PROCESS OF ADMISSION

All decisions to admit are made by a named consultant psychiatrist. The profiles of the patients are male and over 65 years of age. There is on average one admission per calendar month for detoxification. A full assessment is completed on admission and family are contacted as appropriate. There is general observation on the ward.

CARE PLAN

There are no multidisciplinary care plans in place. All discharges are planned. A letter to the patient's GP is completed by the NCHD on discharge.

NURSING PROCESS

The nursing model in use is Peplau and Orem King. All staff on the day of inspection were wearing identification.

ACCESS TO THERAPY

The consultant psychiatrist visits the ward twice weekly. All medical referrals are sent to Wexford General Hospital. A substance abuse counsellor will attend the ward on receipt of a referral. There is no occupational therapist available to the teams. Clinical psychology and social work referrals are by referral from the consultant psychiatrist.

ACCESS TO THERAPEUTIC PROGRAMMES

The patients are not involved in any group or individual therapeutic programme. A number of patients attend activation in the main hospital.

SECLUSION

Seclusion is not used on the ward.

CLINICAL RISK MANAGEMENT

The clinical risk policies are common throughout the service. A number of policies on seclusion, consent and ECT have been developed since the last inspection. There is a policy on control and restraint. Staff are offered training in mandatory courses. Records are kept and held in the nursing administration office.

UNIT MANAGEMENT

The ward staff are centrally rostered. There is one CNM2 and one staff nurse rostered in the daytime. At night there is one staff nurse rostered on duty. Patients requiring long-term care are transferred to the county home, long-stay male ward on site or nursing home accommodation. The ward is locked. Patients are accompanied on leave and there is no CCTV in operation. The female staff are required to wear a uniform, male staff wear casual clothes. All staff carry personal alarms. One patient is awaiting transfer to a nursing home. Visiting times are flexible. Meals are at set times and drinks are provided as required.

SERVICE USER INVOLVEMENT

The treating consultant psychiatrist as required provides oral information to the patient and/or family member. The Irish Advocacy Network services do not visit the ward.

RECORDS

The ward is in the process of introducing new documentation. There is a separate medical and nursing chart. All records reviewed on the day were in order. The medication card index system was in order.

ENVIRONMENT

The ward was located on the first floor of the hospital. The bed area was divided in two by the nursing office. There was also access to a sitting

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room, dining room and consultant office. The ward had shared access to an enclosed garden space and patients must be accompanied while outside. There was an internal smoking room with extractor fan. There were two fire exit points.

ST. CHRISTOPHER'S WARD

Date of inspection: 7th September 2005

Number of beds: 13 male

DESCRIPTION

St. Christopher's Ward is located on the ground floor of St. Senan's Hospital. It is a locked unit and all patients have intellectual disability. All patients are of Voluntary status. The patients range in age from 32 years to 58 years. One bed is designated as a respite bed. All patients have been assessed as requiring alternative accommodation. Three patients are awaiting placement in a nearby town in Respond housing. Seven patients are awaiting 24-hour supervised accommodation but this is not currently available. Two patients require other specialist services, neither of which is currently available.

REFERRAL AND PROCESS OF ADMISSION

No patients are admitted to the ward as it is planned to close the ward as soon as possible.

CARE PLAN

There is no multidisciplinary care plan but there are nursing care plans. There is a team nursing system that is organised around patient groups. The consultant psychiatrist attends the ward weekly and meets with nursing staff but there are no scheduled team meetings.

NURSING PROCESS

The Orem Peplau nursing model is in use on the unit. Staff feel that this is not completely appropriate to the needs of this patient group. There is general observation on the ward.

ACCESS TO THERAPY

There is no input from a psychologist or social worker to the ward. There is no occupational therapist in the service. Access to medical and surgical assessments and treatment can be prioritised.

ACCESS TO THERAPEUTIC PROGRAMMES

There are no needs-based activities on the ward. One patient goes to the activation unit. Nursing staff provide some activities in the form of jigsaws, walks, painting and ball games but due to the small number of nurses on the ward organised activities and individual activities are not usually possible. Some patients are able to go on holiday with staff for a few days. The staff have organised a small relaxation room on the ward which has a beneficial effect for some patients. There is also access to a snoezelen room but again low staffing numbers make this difficult to access. Despite the fact that many patients have communication difficulties there has been no training in sign language appropriate to people with intellectual disabilities.

SECLUSION

Seclusion is carried out on this ward. There is an up-to-date seclusion register and 15-minute observation checklist. There is also a seclusion policy and seclusion episodes were written in the clinical file. The seclusion room was clean with specialised paint and there was a safety bed. The window was safe and there was a panel on the door.

CLINICAL RISK MANAGEMENT

All policies were available on the unit. All staff have been trained in control and restraint techniques, breakaway techniques and cardio-pulmonary resuscitation, and have received refresher courses. A pinpoint alarm system was in operation on the ward. Mechanical restraint is not used on the ward. Serious incidents are reported using a standardised form. Debriefing is available after a serious incident if required.

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UNIT MANAGEMENT

There are no transfers of patients to or from the ward because of bed shortages. There are three nursing staff on the ward during the day and two at night. There is one household staff on duty during the day. Female nurses do not work in this ward and consistency of staff is difficult to maintain due to the small pool of nursing staff in the hospital. There is no CCTV on the ward. Nursing staff perform phlebotomy services. There is no waiting list and all patients are awaiting alternative accommodation. Meal times are at the usual times. Bedtimes are between 2000h. and 2200h.

SERVICE USER INVOLVEMENT

Due to the serious and profound levels of disability there are no information leaflets available for the patients. Information is available for relatives by their request. There is no formal carers support available.

RECORDS

The clinical records were reasonably tidy. The signatures were illegible in some cases and no title of personnel was given in some clinical files. Some files did not have regular psychiatric assessments, mental state examinations and physical examinations documented over the previous few years and in some cases progress notes were scanty. Staff stated that sometimes there was difficulty in accessing medical staff for review of patients. The medication sheets were legible. Nursing care plans were satisfactory.

ENVIRONMENT

The ward was in extremely poor condition and completely unsuitable for patients. It was bare and needed repainting. Plaster was crumbling off the wall in some areas. There were two separate day areas which had few comfortable features. There were three 4-bedroom dormitories that were bare. There were no curtains around the beds and no privacy for patients. Wardrobes were individual but located outside the dormitory. In one dormitory there was severe damp; the plaster was coming off the wall and falling on one of the beds. Part of the drainpipe

outside this area had been missing for some time. There was a leak in the ceiling with buckets placed under it to catch the water. The bathroom needed tiling and new fixtures. The dining room was bare apart from table and chairs. There was a pleasant garden and patio area.

ST. CLAIRE'S WARD (ADMISSION)

Date of inspection: 7th September 2005

Number of beds: 13 male

DESCRIPTION

St. Claire's Ward is a male admission ward located in St. Senan's Hospital. It is a locked ward and at the time of inspection had seven patients on Temporary status. There are two sector teams, a POLL team and a Rehabilitation team admitting to the ward. Patients may be referred, following treatment, to the pre-discharge ward located in the hospital.

REFERRAL

Most patients are referred by their GP. Occasionally patients are self-referrals. On occasion consultant psychiatrists may refer patients from the outpatients department.

PROCESS OF ADMISSION

There is an admission policy. All patients are seen and examined by the NCHD. The decision to admit a patient is made by the NCHD and the consultant psychiatrist is contacted if there are any difficulties in the admission process. There are occasional admissions of children under 16 years to the ward. Occasionally, people with moderate intellectual disability are also admitted to the ward. There are frequent admissions for alcohol and drug detoxification and at the time of inspection six patients were undergoing detoxification. Patients are reviewed by the consultant psychiatrist within 24 hours. There is no policy on patients being nursed in their night clothes. It was stated that this practise is based on patient need.

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CARE PLAN

There is no multidisciplinary care plan but there is a nursing care plan. There are weekly sector team meetings on the ward attended by nursing staff, medical staff and community mental health nurses.

NURSING PROCESS

The Orem Peplau nursing model is in use on the ward. Staff feel that this is completely appropriate to the needs of this patient group. There are two levels of observation on the ward: general observation and one-to-one (special) observation but no high observation area. There is a primary nurse system in place.

ACCESS TO THERAPY

Input from a psychologist or social worker to individual patients is through referral by the consultant psychiatrist. There are also six-week group programmes for patients. There is no occupational therapist in the service. There is access to sector addiction counsellors. The consultant psychiatrist attends the ward two or three times a week.

ACCESS TO THERAPEUTIC PROGRAMMES

There are no therapeutic activities on the ward. Some patients go to the activation ward.

SECLUSION

Seclusion is carried out on this ward. There is an up-to-date seclusion register and 15-minute observation checklist. There is also a seclusion policy and seclusion episodes were written in the clinical file. The seclusion room was clean but bleak, with a safety bed. The window was safe and there was a panel on the door. CCTV is not used.

ECT

ECT is administered in an ECT suite on the second floor of the hospital. There is a large waiting area, an adequately equipped treatment room and a large recovery room. An ECT register was available. Pre-ECT and post-ECT checklists were used and there were written consent forms. There is a designated consultant psychiatrist for ECT and nursing responsibility for ECT rotates between the acute ward and the pre-discharge ward.

CLINICAL RISK MANAGEMENT

All policies were available on the ward. All staff have been trained in control and restraint techniques, breakaway techniques and cardio-pulmonary resuscitation and have received refresher courses. A pinpoint alarm system was in operation on the ward. Mechanical restraint is not used on the ward. Serious incidents are reported using a standardised form which is analysed by a risk assessor. Debriefing is available after a serious incident if required.

UNIT MANAGEMENT

There are frequent transfers of patients to other wards because of bed shortages. At the time of inspection there were four patients sleeping in other wards in the hospital. There are four nursing staff on the ward in the daytime and two staff nurse at night. There is one household staff on duty during the day. There are no activities on the ward and leave from the ward is documented in the patient's clinical file. The external door is usually locked, there is no policy on locking the door. CCTV is not used on the ward. There is no ward clerk. The ward continuously operates at above 100% occupancy. There is no waiting list and no bed management procedure. Visiting times are open.

SERVICE USER INVOLVEMENT

Information leaflets and notices were displayed in the ward. Information on patients' rights and complaints procedures were displayed. There is access to the Irish Advocacy Network who visit every two weeks.

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Patients complained of boredom and stated that the ward was too small. One patient complained of the lack of confidentiality due to the cramped nature of the ward.

RECORDS

The clinical records were reasonably tidy. The signatures were illegible in some cases and no title of personnel was given in some clinical files. Nursing care plans were satisfactory. Medication sheets were up to date and were legibly signed.

ENVIRONMENT

The ward was small and there was a very small entrance lobby. There is no high observation area. There was one dormitory that was cramped with little space between the beds and in some cases there was not enough room for a wardrobe. The interview room was located in the dormitory area. Staff stated that this causes disturbance at night if a patient is being admitted. Some patients request to sleep in the seclusion room in order to have an undisturbed night. The bathroom was in poor condition. The toilets had paint peeling from the walls and needed to be tiled. There was a day room with worn chairs which doubled as a dining room. It had a TV and table football. The kitchen had damp and mildew on the walls. The patients could access the grounds if allowed leave from the ward but it is planned to develop an enclosed garden. The nurses' office was centrally located. The walls were open at the top which meant that all conversations and discussion held in the office could be overheard in the dormitory.

ST. ELIZABETH'S WARD

Date of inspection: 7th September 2005

Number of beds: 16 female

DESCRIPTION

This is a ward with 16 female beds for care of the elderly. It is a locked ward and on the day of inspection there was one patient on Temporary status.

REFERRAL

The source of referral to St. Elizabeth's Ward is the Acute Ward and St. Gertrude's Ward. The CNM2s of either ward make contact to ascertain whether there is a vacant bed and the transfer is arranged.

PROCESS OF ADMISSION

There are no direct admissions to this ward, only internal transfers. A full psychiatric assessment is already completed prior to transfer and the identified care plans are continued on St. Elizabeth's Ward. The consultant psychiatrist makes the decision to transfer the patient. Communication with the patient is encouraged where possible, as well as with family members. There is one consultant psychiatrist who has responsibility for the ward. The treatment plan is contained in one single set of notes. There is a key worker system on the ward.

CARE PLAN

Care planning is nurse led and identifies need and contains goals and objectives. Care plans are reviewed by the key worker on a three-monthly basis. It was reported that the population on this ward was static and that there are no discharges.

NURSING PROCESS

The ward incorporates Peplau and Orem models of nursing. It was described as appropriate to the needs of the patient. It is implemented by a key worker. There were no formal risk assessments carried out. All staff wear uniform.

ACCESS TO THERAPY

There is a referral system to a psychologist and social worker. There is one consultant psychiatrist with responsibility for the patients on the ward although there was no evidence that the consultant psychiatrist reviews the patients. There is contact with the NCHD which was described as very good. All patients have access to pastoral care services.

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ACCESS TO THERAPEUTIC PROGRAMMES

There are limited activities within the ward. There are music and singing groups. There is access to TV and some of the patients access the canteen within the hospital. On special occasions there are parties.

CLINICAL RISK MANAGEMENT

There are policies on risk management, alcohol, illegal drugs, patients going missing, the management of violent episodes, rapid tranquillisation and on giving medication without consent. As with the other wards in this hospital, there is a comprehensive policy folder. There is a safety policy for the use of mechanical restraint. Staff are in receipt of appropriate mandatory training. There is no formal clinical risk assessment undertaken. Serious incidents are recorded on appropriate forms and feedback is obtained regarding these.

UNIT MANAGEMENT

Patients from the ward do not sleep out on other units, although it is reported that sometimes patients are transferred in from other units. Patients are allowed off this ward if appropriate. The door is locked as some patients may wander. There are three qualified nurses on duty during the day and one at night. These numbers appeared low considering the high dependency of the patients. Staff are rostered to the ward through a central rostering system although there are some core staff. There is one household member of staff on duty. Maintenance is provided by the maintenance team within the hospital. Visiting times to the ward are flexible. Meal times are set and there is availability of snacks and drinks.

SERVICE USER INVOLVEMENT

There is some information available on rights and there is a complaints procedure. Carers and family members' opinions are sought when they visit the ward. There is also access to an advocacy network.

RECORDS

As with other wards in the hospital the patients all had a single file. It contained the name and ID number on all pages. Files were legible and tidy. The entries in the notes had full names and titles of personnel and they were signed and dated. There were no progress reports from allied health professionals and there was no documented review by the consultant psychiatrist. The medical interventions are from the NCHD as requested by nursing staff. Nursing care plans are up to date and regularly evaluated. The drug index cards were signed, dated and legible though it was noted that some required rewriting. The chart of a person who was involuntarily admitted was reviewed and was satisfactory.

ENVIRONMENT

This is a 16-bed ward within a psychiatric hospital. There was disabled access and appropriate light and ventilation. The décor of the ward needed updating. There was a dedicated visitors' area. Bedroom areas were either a five-bed or nine-bed dormitory. There was also a single room. There were curtains around the beds and individual wardrobe space. Toilets and bathrooms were of a satisfactory standard. The dining area had space for one seating. It was reported that a number of household items were required for the ward. The lounge area had comfortable seating. There was access to newspapers, TV and books. The nurses' station was situated centrally within the ward. There was adequate space for report writing, it was accessible, had a telephone system but no IT system and this was reported as being needed. There was an alarm system in operation. The clinical room had all the appropriate equipment and storage needed. There was adequate storage within the ward for patients' possessions, files, records, medication and linen. There was no money held within the ward and the ward ran a credit system with the shop.

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ST. ENDA'S WARD

Date of inspection: 7th September 2005

Number of beds: 20

DESCRIPTION

This is a 20-bed male rehabilitation ward. It is under the clinical direction of one consultant psychiatrist. It is an open ward. On the day of inspection, there were 19 patients, two were of Temporary status under The Mental Treatment Act 1945. The age profile of the group is from 32 to 82 years.

REFERRAL

All referrals are through the consultant psychiatrist. All referrals came from other wards in the hospital. Patients are assessed prior to transfer.

PROCESS OF ADMISSION

Each patient admitted has a full assessment including a physical examination. The consultant psychiatrist takes all decisions regarding admissions. Patients are on general levels of observation.

CARE PLAN

There is no multidisciplinary rehabilitation team in place. There are no active discharges.

NURSING PROCESS

The nursing model in use is a combination of the Orem King and Peplau models. All patients are on general level of observation.

ACCESS TO THERAPY

The consultant psychiatrist visits weekly. Medical and surgical consultations are sent to Wexford General Hospital. There are frequent referrals to physiotherapy and chiropody services.

ACCESS TO THERAPEUTIC PROGRAMMES

Some patients attend a number of programmes off the ward. These include working on the hospital farm, workshop, occupational therapy and Skills Base.

SECLUSION

Seclusion is not in use on the ward.

CLINICAL RISK MANAGEMENT

The clinical risk policies are common throughout the service. A number of policies on seclusion, consent and ECT have been developed since the last inspection. There is no policy in place on the use of restraint. Staff are offered training in mandatory courses. Records are kept and held in the nursing office.

UNIT MANAGEMENT

The ward is open and there is no CCTV in operation. Nursing staff are rostered centrally and there is little consistency in the staffing. There is one CNM2 and one staff nurse rostered in the daytime and one staff nurse by night. The female staff wear uniforms. There is no waiting list for admission. On the day of inspection, the nurse manager reported that 14 of the 19 patients could be accommodated in a 24-hour nurse-staffed community residence if it was available and three of the 19 patients were suitable for nursing home accommodation. Meal times are at set intervals and visiting times are flexible.

SERVICE USER INVOLVEMENT

There is no formal process in place for user involvement. All complaints are dealt with using local area policies.

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RECORDS

The medical and nursing notes reviewed on the day were in order. The medications card index had been recently rewritten and was very clear. One patient was self-medicating while on weekend leave.

ENVIRONMENT

The ward is located in an old hospital building. There were four single rooms. The other sleeping area was divided into dormitory areas with four, five and seven beds. The toilet and bathroom areas were in poor repair and required immediate upgrading. There was only one shower and one bathroom for 19 patients.

ST. FIDELMA'S WARD

Date of inspection: 7th September 2005

Number of beds: 16

DESCRIPTION

This is a care of the elderly female ward. The ward is locked. On the day of inspection, there was one patient on Temporary status and one Person of Unsound Mind (PUM). All others were on Voluntary status. Three consultant psychiatrists have admitting rights to the ward.

REFERRAL

All referrals are through a consultant psychiatrist. All new admissions are internal transfers.

PROCESS OF ADMISSION

There is no admission policy. All decisions to admit are taken by the consultant psychiatrist. The clinical notes accompany the patient. There is general observation on the ward.

CARE PLAN

There are no multidisciplinary care plans in place. There are no active discharges.

NURSING PROCESS

The nursing models in use are the Peplau and Orem King models. There is a key nurse system in place.

ACCESS TO THERAPY

There is no multidisciplinary team input into the ward. The consultant psychiatrists visit on request and complete the six-monthly reviews. They will visit as requested outside that time. The NCHD visits as requested. There is access to a physiotherapy service by referral.

ACCESS TO THERAPEUTIC PROGRAMMES

A number of patient who are mobile attend bingo in the main hospital. There is no structured programme in place for patients. Pastoral care services are available to all patients.

SECLUSION

Seclusion is not in use on the ward.

CLINICAL RISK MANAGEMENT

The clinical risk policies are common throughout the service. A number of policies on seclusion, consent and ECT have been developed since the last inspection. There is no policy in place on the use of restraint. Staff are offered training in mandatory courses. Records are kept and held in the nursing administration office.

UNIT MANAGEMENT

The door to the ward is locked. There is no CCTV in operation. The staff are rostered centrally. During the day there is one CNM2 and two staff nurses on duty, at night there is one staff nurse. The nursing staff are all in uniform. The NCHD takes blood as required. Meals are at regular set intervals and visiting time is flexible.

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SERVICE USER INVOLVEMENT

Verbal information is provided as requested. Patient and carers' opinions are not actively sought.

RECORDS

The medical notes reviewed showed clear evidence of six-monthly physical examinations. There was not always a six-monthly mental state review present. A patient identifier was not present on each sheet. The nursing notes reviewed were in order. A signature bank was only available for nursing staff. The medication card index system was in order. The medication sheets had been recently rewritten.

ENVIRONMENT

The bedroom area was in two distinct areas of 13 beds and three beds. There was also access to a day room. The visitors' room and smoking room were shared with a neighbouring ward. On the day of inspection, the Inspectorate was informed that new carpet tiles and new floor covering for the kitchen were ordered. There was limited access in the shower area. There was no hot running water in the wash-hand basins next to the toilet.

ST. GERTRUDE'S WARD

Date of inspection: 7th September 2005

Number of beds: 27 integrated

DESCRIPTION

This is a 27-bed ward within St. Senan's Hospital. It is described as a continuing care ward and regularly receives patients from the acute wards for overnight stays.

REFERRAL

The source of referral to this ward is the acute units within St. Senan's Hospital. The sector consultant psychiatrist contacts the consultant psychiatrist with responsibility for the ward with a request for an

internal transfer. There is no ward staff input to the transfer procedure.

PROCESS OF ADMISSION

All admissions to this ward are internal transfers, therefore a full history is already taken and the NCHD continues to monitor the physical well-being of the patient. The consultant psychiatrist makes the decision to transfer to this ward. The staff on the ward explain the care plans to the patient on admission and where possible involve family members.

CARE PLAN

Care plans are all nurse led on the ward. They identify the needs and produce goals and objectives to be achieved. Care plans are reviewed on a monthly basis and progress notes are written each week. If a patient is to leave the ward there is a gradual process of discharge. Patients initially have leave to either a hostel or to their home. Once this has been successfully managed they are discharged.

NURSING PROCESS

The ward uses the Orem Peplau model of nursing. The staff reported to the Inspectorate that this was not appropriate to the needs of the patient group and it was described as being repetitive. The implementation is nurse led and there is no formal risk assessment applied to the model.

ACCESS TO THERAPY

The psychologist and social worker are available through referral and there is an activation ward on site. The ward has access to an addiction counsellor. There are three consultant psychiatrists who have admitting rights to the ward and they review patients weekly. Pastoral care services are available to all patients.

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ACCESS TO THERAPEUTIC PROGRAMMES

There are some activities available on the ward. Art and tapestry are available on a weekly basis, along with games. Staff reported that they try to get the patients out of the ward as much as possible. It was also reported that some of the patients go to the activation ward.

CLINICAL RISK MANAGEMENT

There is a policy on risk management available. There is an alarm system in operation. There are also policies on the following: alcohol and illegal drugs, patients absconding, the management of violent episodes, the use of rapid tranquillisation, policy and procedure on giving medication without consent and patients being searched. The staff receive training in control and restraint techniques, including de-escalation and breakaway techniques. There is also other mandatory training occurring such as cardio-pulmonary resuscitation, and lifting and handling. Serious incidents are recorded on appropriate forms and sent to the Assistant Director of Nursing. They are then forwarded on to the Director of Nursing and the health and safety team who provide feedback to the ward.

UNIT MANAGEMENT

The ward receives patients from the acute wards on a regular basis to sleep overnight. Beds are allocated within the ward to accommodate patients staying overnight. Admission patients are escorted to the ward from the acute ward and spend the night on St. Gertrude's ward, returning the next day to the acute ward. Patients are given leave from the ward and there is an open door policy. There are two staff on duty during the day and one at night. The staff are provided through a central rostering system but there are core staff. There is one household member of staff on duty. Staff all wear uniform. It was reported that there are no patients currently waiting for an appropriate discharge placement. Maintenance is carried out by the maintenance team from the hospital. It was reported that the ward requires a dishwasher and a new food trolley. Visiting times to the ward are flexible. Meals are at set times and there is availability of snacks and drinks in between meals.

SERVICE USER INVOLVEMENT

There is some information on treatment and therapies and patients' rights. There is a complaints procedure in place. There are no formal mechanisms for obtaining patients or carers' view of the ward although there is an informal process on interactions with the staff. The Irish Advocacy Network call to the ward.

RECORDS

The patients' names and ID numbers were not always on the pages in the files. Entries had full names and titles of personnel and were signed and dated. There were no progress reports from the allied health professionals. There was evidence of a treatment plan which was dated and signed with progress reports. The consultant psychiatrist reviews weekly and the NCHD reviews the patients when asked by the nursing staff. The nursing files were legible and tidy and contained up-to-date care plans which were regularly reviewed. Drug charts were signed and dated and used generic names.

ENVIRONMENT

This was a 27-bed large ward situated in a psychiatric hospital. It has a regular maintenance programme. The ward was situated on the second floor of the building and disabled access was restricted due to the narrow doorways and toilet areas. There was a lift for people to access the ward. The décor of the ward was of a good standard and there was appropriate ventilation. There was a dedicated visitors' area but no access to a garden as they were on the second floor. The bedroom areas contained a number of dormitories. They ranged from four people sharing to nine people. All patients had their own wardrobe space and had their own clothes. There were curtains around each of the bed areas. Toilets and bathrooms were of a good standard and freely accessible and gender specific.

The dining area had space for all patients at one sitting, there was self-service and it was integrated. The lounge area had comfortable seating and the patients had access to newspapers, TV, radio and books. The nursing station was central within the

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ward. It provided adequate space for report writing, was accessible and had a telephone system. The clinical room had appropriate storage for medication and medical equipment and contained cardio-pulmonary resuscitation equipment, oxygen suction and clinical waste.

PRE-DISCHARGE UNIT

Date of inspection: 7th September 2005

Number of beds: 15 integrated

DESCRIPTION

The pre-discharge unit is located on the second floor of St. Senan's Hospital. It is an open unit. The main emphasis is on preparing patients for discharge following admission to the acute unit. The length of stay ranges from three weeks to six months and all patients are of Voluntary status.

REFERRAL

Patients are referred from the admission wards and referrals come through the sector team meetings.

PROCESS OF ADMISSION

All patients have had a physical and psychiatric assessment prior to admission to the unit. Patients remain under the care of their sector consultant psychiatrist. An initial treatment plan is documented.

CARE PLAN

There is no multidisciplinary care plan. There is a nursing care plan. There is a key worker system, organised by sector. There are weekly team meetings of each sector. The team responsible for the rehabilitation patients review them once a week with medical and nursing staff. The psychologists and social workers do not attend the sector team meetings but the psychologist does attend the rehabilitation team meeting.

NURSING PROCESS

The Orem Peplau nursing model is in use on the unit. Staff feel that this is appropriate to the needs of the patients.

ACCESS TO THERAPY

Access to a psychologist and social worker is through referral. There is no occupational therapist in the service.

ACCESS TO THERAPEUTIC PROGRAMMES

Patients attend the activation unit on the grounds of the hospital, sheltered workshops and a garden centre. Most patients attend activities out of the unit and there are no unit based activities.

SECLUSION

No seclusion is carried out on this ward.

CLINICAL RISK MANAGEMENT

All policies were available on the unit. All staff have been trained in control and restraint techniques, breakaway techniques and cardio-pulmonary resuscitation. A pinpoint alarm system was in operation on the ward.

UNIT MANAGEMENT

Patients from the admission wards frequently sleep in the pre-discharge unit due to bed shortages in the admission units. As part of their programme patients are responsible for keeping their own room tidy, cooking their own meals and doing their own laundry. Bedtimes are flexible and patients can come and go from the ward as they wish. There are two nursing staff on the ward in the daytime and one staff nurse at night. There is one household staff on duty during the day.

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SERVICE USER INVOLVEMENT

There are information leaflets available for the patients. Notices about the complaints policy were displayed. The Irish Advocacy Network visits the ward every two weeks.

RECORDS

The clinical records were reasonably tidy. They contained up-to-date progress notes which were dated and signed. The signatures were illegible in some cases and no title of personnel was given in some clinical files. The medication sheets were recently rewritten and nursing care plans were satisfactory.

ENVIRONMENT

The unit was located along a long corridor. Each patient had a single room, and the rooms all had wardrobes and personal belongings. There was a small smoking room. The toilets were clean but there was only one shower. There were three bathrooms. There was an adequate interview room. The sitting room was homely and comfortable with TV, radio and a large selection of books.

WEXFORD

ARDMINE RESIDENCE

Date of inspection: 8th September 2005

Number of beds: 13

DESCRIPTION

Ardmine Residence is located in Riverchapel Village. It is a former holiday home and opened as a residence in 1987. The house is located in the village on a large site. There are 13 residents – six male and seven female. Nine of the residents are over 65 years. The range of ages is from 54 to 83 years.

REFERRAL

The last admission to the residence was 18 months ago. All referrals are through a consultant psychiatrist. The residence is primarily for continuing care.

PROCESS OF ADMISSION

The consultant psychiatrist reviews all new admissions to the residence. The GP completes a yearly physical examination on each resident. The consultant psychiatrist reviews each patient every six months.

CARE PLAN

There are no multidisciplinary team care plans in place. There was one discharge in 2004 to a district hospital and the beds were reduced from 14 to 13 beds.

NURSING PROCESS

The nursing model in use is the Peplau Orem King model. There is a key nurse system in place.

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REHABILITATION TEAM

There is no multidisciplinary team in place. The consultant psychiatrist visits every six weeks or as required. The residence has visits from a physiotherapist, chiropodist, aromatherapist and hairdresser.

INVOLVEMENT IN REHABILITATION PROGRAMMES

The focus within the residence is on quality of life. One resident attends a day centre for the elderly once a week. All other residents remain in the residence, have hobbies and use the local facilities within the village. The residence has a garden tunnel and some residents, with the assistance of staff, are included in gardening activities.

CLINICAL RISK MANAGEMENT

The main risk is currently with falls and wandering. The staff are aware and are putting practices in place to address these issues.

UNIT MANAGEMENT

The residence is staffed by one CNM2 and one domestic staff in the daytime. At night there is one staff nurse rostered for duty. All staff wear casual clothing. There is no waiting list for admissions. The residents are moving towards an older age profile. The hospital maintenance is provided by the Wexford Mental Health Association.

HOUSE RULES

Staff design the house rules and residents are consulted. Visiting time is flexible and all residents have visitors on a regular basis. The front door is open during the day and residents are free to come and go. Residents are unable to lock bedroom and bathroom doors. There are three single rooms and four double bedrooms in the house. All meals are prepared on site by a household staff member. All shopping is completed locally and delivered to the house. Residents have access to the kitchen to make

hot drinks. All residents have a post office account. Most residents have money collected by staff due to limited mobility and all money collected is recorded. Residents are assisted with shopping for clothes, depending on ability. The residence is centrally located in the village and the residents are well integrated. They use the public facilities. The residence has a minibus and bring residents to the nearest large town on a weekly basis or as required.

SERVICE USER INVOLVEMENT

Oral information on treatment is provided to residents on request. All residents are registered to vote and the residence has access to a postal vote facility. There is no log of complaints. A community meeting is held every three months and minutes are kept. The residence has had one visit from the Irish Advocacy Network service.

RECORDS

The records reviewed on the day of inspection showed clear evidence of active case reviews by the medical and nursing teams. There were typed letters of case reviews in place. The card index system was in order. No resident is currently self-medicating. There were written operational guidelines in place specific for the residence.

ENVIRONMENT

The residence is a large two-storey house. The house was originally two houses that had been adapted into one home. There was one single bedroom downstairs. Each staircase had a stair-lift in place to aid mobility of the older residents. There were a number of access problems with the downstairs shower area. The residence staff felt that residents should remain in the residence for as long as possible despite their increasing age. However the physical environment limited their capacity to achieve this.

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58 WESTLANDS*Date of inspection:* 8th September 2005*Number of beds:* 9**DESCRIPTION**

This residence is part of a Respond housing complex. There are eight residents with intellectual disability, all of whom have been former patients in St. Senan's Hospital. The residence was opened in 1995.

REFERRAL

All referrals to the residence are through a consultant psychiatrist. There are no active admissions or discharges.

PROCESS OF ADMISSION

There is no written policy on admissions criteria. All new referrals are assessed by a named consultant. The consultant psychiatrist visits the residence and reviews the residents every six weeks. All residents are registered with a GP and have annual physical examinations.

CARE PLAN

There are no multidisciplinary care plans in place. The nursing staff review care plans on a regular basis. The staff are in regular contact with a number of agencies that provide sheltered work and activities for the residents off site.

NURSING PROCESS

The Roper Logan Tierney Model of nursing is in use. Each resident is allocated a key nurse.

REHABILITATION TEAM

There is no dedicated rehabilitation team. There are regular reviews in place by the consultant psychiatrist. The staff access appropriate personnel in community

care as required. All residents have regular appointments with dental services, chiroprapist, and aromatherapist.

INVOLVEMENT NO REHABILITATION PROGRAMME

A number of residents attend sheltered work and day centres off site. These activities are based on a needs assessment. Other residents are involved in household tasks. There is clear evidence of staff encouraging residents and developing a homely atmosphere.

UNIT MANAGEMENT

The residence is staffed by one CNM2 and one domestic staff in the daytime. At night one staff nurse is rostered on duty. A number of residents have limited mobility and require the assistance of two people in activities of daily living. All staff wear casual clothing. There is a strong ethos of providing a permanent home for the residents. There are currently eight people on a waiting list for admission. Informal feedback is requested from families on the quality of care provided. The residence maintenance programme is provided by the maintenance staff in St. Senan's Hospital. The Wexford Mental Health Association provide assistance in the decoration of the residence.

HOUSE RULES

The house rules are designed by staff and residents. There is an open and flexible approach to visiting hours. All residents can lock their bedroom and bathroom doors. Residents can leave the house unsupervised but are requested to let staff know. Meals are prepared on site and residents are involved in meal planning as appropriate. The residents have free access to the kitchen during the day. There are plans to reduce the numbers by one to reduce crowding in the sleeping area. There are no set bedtimes. There is a clear and transparent financial system in place for the management of residents' monies. Each resident has a lodgement book detailing their pocket money. All monies are collected by staff and lodged in bank accounts. Letters have

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been sent to families outlining the procedure. All residents have received letters regarding the suspension of rent charges.

Residents and staff access local facilities for leisure and shopping activities. The house has access to a minibus. Some activities are curtailed due to staffing levels and physical needs of some residents.

SERVICE USER INVOLVEMENT

Residents are provided with verbal information. Three residents are registered to vote. Complaints are rare and dealt with through the local complaints procedure. There are informal house meetings. The Irish Advocacy Network service has visited the house once.

RECORDS

There were no medical records on site; the records are filed in St. Senan's Hospital. The nursing files reviewed were of a very high standard and demonstrated clear evidence of regular review and high documentation standards. There was a signature bank in place. The medication system was in order. A number of residents who attend work are given their medications for each day.

ENVIRONMENT

This is a two-storey house located in a Respond housing complex. The house was bright, homely and well laid out. There are currently three double bedrooms and three single rooms and there were four bedrooms downstairs. There was access to a garden area. The house had an internal smoking room located on the ground floor.

STAFF TRAINING

The staff receive regular updated training in mandatory courses.

WATERFORD REGIONAL HOSPITAL

DEPARTMENT OF PSYCHIATRY

Date of inspection: 6th September 2005

Number of beds: 45 integrated

DESCRIPTION

The Department of Psychiatry is an acute admissions unit on the lower ground floor in Waterford Regional Hospital. There are 45 beds on the unit. This includes a separate high observation area of 11 beds. Six beds in the main unit are allocated to the Old Age Psychiatry service. On the day of inspection, there were 28 patients, 14 male and 14 female. Four patients were on Temporary status and all others were on Voluntary status. There are five teams with admitting rights to the unit.

REFERRAL

Sources of referral include GPs, out patient clinics, community mental health teams, the team for old age psychiatry and the A&E in the hospital. Triage is provided in the A&E and two liaison nurses specialise in parasuicide and alcohol-related problems respectively.

PROCESS OF ADMISSION

There is an admission policy. Children under 16 years of age are not normally admitted. People with moderate intellectual disability are admitted if there is an overriding mental health problem. There are no admissions for uncomplicated detoxification. In A&E, patients are assessed by an NCHD and all decisions to admit are discussed with the sector consultant psychiatrist or the consultant on call. All patients who are admitted have a full psychiatric and physical assessment. Patients are reviewed by the consultant psychiatrist within 24 hours of admission. The initial treatment plan is formulated by the NCHD in consultation with a consultant psychiatrist and this is communicated to the patient by the NCHD and nursing staff. If appropriate, families are advised of the admission and a collateral history is taken. Patients are nursed in their night clothes following admission until the consultant psychiatrist decides

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otherwise. The patient is allocated a key nurse, who works with patients of a particular sector or team.

CARE PLAN

There was no evidence of multidisciplinary care planning on the unit. There are weekly multidisciplinary meetings of the sector and Psychiatry of Later Life (POLL) teams. The key nurse undertakes an assessment of the patient and formulates a nursing care plan. Objectives are set which are evaluated on a daily basis. If deemed appropriate, a referral is made to an occupational therapist, social worker or psychologist. A discharge policy is in place. The patient is involved in discussion of the initial assessment and in the discharge process, and is invited to attend pre-discharge meetings at which a discharge plan is put in place.

NURSING PROCESS

The Orem Peplau model of nursing is in use on this unit. This does not contain a formal risk assessment. Patients are under a general level of observation unless they are being nursed in the high observation area. The female nurses wear uniforms. All staff wear identification badges.

ACCESS TO THERAPY

There are five teams admitting to the unit but not all teams have a full multidisciplinary complement. There is access to one occupational therapist, three social workers and three psychologists in total. Three addiction counsellors are based in Brook House. The consultant psychiatrists visit the unit on a daily basis. NCHDs provide medical care and there are agreed protocols for medical and surgical consultations in the main hospital. Laboratory and X-ray results can be accessed quickly.

ACCESS TO THERAPEUTIC PROGRAMMES

There is no occupational therapist based on the unit. A member of nursing staff provides a range of groups and individual sessions for patients five days a

week. A section of the unit is dedicated to this purpose. Student nurses are also involved in providing this service.

ECT

There is an ECT suite, comprising a waiting area, preparation room, treatment room and recovery room. There is an ECT policy, a designated consultant psychiatrist and a team of nurses who are trained in ECT. Patients receive written information on ECT. The consultant psychiatrist obtains the patient's consent. There is a nursing procedure and checklist and records of ECT are kept in the ECT room.

SECLUSION

There is a policy on seclusion. There is a nursing checklist and the seclusion register was maintained. The seclusion room is located in the high observation area. The room was clean and safe. It was well ventilated and had good lighting. It also had easy access to a toilet. CCTV is used to monitor the patient in seclusion and the door, which had two-way opening, had an observation panel.

CLINICAL RISK MANAGEMENT

There is a policy on risk management in place. There is an alarm system on the unit and all staff wear personal alarms. There are policies on alcohol and illegal drugs, patients going missing, the management of violent episodes, rapid tranquillisation, giving medication without consent, and control and restraint. Restraint is documented in the patient's file. An inventory of the patient's belongings is taken on admission. There is an ongoing programme of training for staff on the unit. This includes training in control and restraint, and de-escalation techniques, cardio-pulmonary resuscitation, and lifting and handling. There is a system for reporting and auditing serious incidents.

UNIT MANAGEMENT

There are long-term transfers to St. Enda's ward and St. Aidan's ward in St. Otteran's hospital. The main

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part of the unit is open. The unit is not used for any other purpose. There is central rostering. There is an induction process and an induction pack for new staff. The unit is staffed by eleven nurses in the daytime and four at night. Five household staff come in on a contract basis. A ward clerk is available part-time. Phlebotomy services are provided from the main hospital. Visiting times are flexible. Tea and coffee are provided during the day. Most patients can access the hospital shop or café or use a kitchenette on the unit. Meal times are at 0815h, 1245h and 1715h.

SERVICE USER INVOLVEMENT

A booklet is provided for patients with information on their rights and on the complaints procedure. A range of leaflets and fact sheets are also provided. There is no formal method of seeking the views and opinions of patients and family or carers on the service. There has been no access to an independent advocate to date but discussions have been taking place to introduce this service.

RECORDS

The patients' files were tidy, legible and all entries were signed and dated. They contained treatment plans and progress notes. The titles of personnel were not always used. There was little evidence of progress notes from occupational therapists, social workers and psychologists. A signature bank was available for nursing staff. The medication prescription and administration sheets were in good order.

ENVIRONMENT

The unit was clean and bright and the décor was of high quality. The corridors were wide and the unit had good light and ventilation. There was a clearly defined reception area with a receptionist present. There was seating in this area and information leaflets were available. The doors to the unit were unlocked. There were two nursing offices, one on the main unit and one in the high observation area. There were two interview rooms with alarms,

observation panels and appropriate seating. The clinical room contained oxygen, suction, cardio-pulmonary resuscitation and materials used for phlebotomy and dressings. The drugs storage area was appropriate. There was no examination couch. The dining room and lounge areas were quite large and had sufficient seating. There was an internal smoking room. Exercise and leisure facilities and equipment were provided in a designated area. There was a garden area, which was being developed with the financial assistance of a voluntary organisation, but this area was not accessible to patients. There was no designated visitors' room or quiet room. Accommodation on the unit was provided in the main unit in a range of single, 2-bed, 4-bed and 6-bed rooms. In the high observation area there were two single rooms and two 4-bed rooms. A maintenance programme is in place for the painting of the unit. There was a sufficient number of toilets and bathrooms, including an assisted bath in the high observation area.

ST. OTTERAN'S HOSPITAL

ST. AIDAN'S WARD

Date of inspection: 6th September 2005

Number of beds: 23 integrated

DESCRIPTION

This is a unit with 23 beds providing ongoing care for dementia patients who present with aggressive challenging behaviour. There is also one respite bed. It is a locked unit and on the day of inspection there were nine patients on Temporary status.

REFERRAL AND PROCESS OF ADMISSION

The only source of referral is through the psychiatry of old age service. At present the process of referral is all admissions are through the consultant psychiatrist. On admission a full psychiatric assessment is undertaken and a physical examination, which is repeated on a six-monthly basis. The consultant psychiatrist makes the decision to admit to the unit. Communication with the patient is made wherever possible and the unit staff spend a large

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amount of their time in communication with family members to ascertain patients likes and dislikes and relatives are encouraged to visit the unit prior to admission. There is also a community liaison nurse who visits the relatives to answer any questions and allay any anxieties. The consultant psychiatrist reviews patients on a weekly basis and the initial treatment plan is documented in the nursing and medical notes. There is no key worker system.

CARE PLAN

Care plans are all nurse led. It is reported that they are needs identified and involve appropriate people in meeting those needs. Goals and objectives are established and the care plans are reviewed on a weekly basis. When patients' needs cannot be met on this unit they are transferred to nursing homes or St. Patrick's Geriatric Hospital. Respite patients go home. It is reported that the key philosophy on this unit is to maintain patients' mobility. Once they become incapable of being ambulant they are reviewed and an alternative placement is found.

NURSING PROCESS

The unit uses a combined Peplau and Orem nursing model. It was described as being appropriate to the needs of the patients and is implemented by the nursing staff. There are some elements of risk assessment in particular the Waterlow scale which assesses the patient's pressure area needs. The staff are identifiable by a uniform.

ACCESS TO THERAPY

There is a referral system to a psychologist and social worker and there is occupational therapy available within the hospital. It was reported that the response from psychology and social work is good when it is requested. Patients' physical well-being is maintained by the NCHD who consults with the Waterford Regional Hospital if there are any difficulties. There are other services visiting the ward such as chiropody and physiotherapy. It was also reported that a local shoe shop provide footwear for the patients and ensures that appropriate and adequate footwear is purchased.

ACCESS TO THERAPEUTIC PROGRAMMES

It was reported that the staff try to keep people as active as possible and encourage family involvement. A large portion of time is spent looking after patients' physical needs but the staff are encouraged to talk to the patients regarding their likes, dislikes, their history and their family. They watch TV together and provide reminiscence therapy. There are also regular outings and themed parties.

CLINICAL RISK MANAGEMENT

There are policies in place regarding clinical risk management, patients absconding, the management of violent episodes, rapid tranquillisation, and giving medication without consent. The staff are trained in control and restraint techniques, which incorporate de-escalation and breakaway techniques. The staff also undertake training in manual handling, lifting, fire, and wound management, and attend other seminars. Staff are also encouraged to undertake degree and masters courses. Serious incidents are recorded on appropriate forms and sent to the risk management department. There is some auditing of this process.

UNIT MANAGEMENT

Patients are accompanied off the ward. There is an excellent garden facility. The door to the ward is always locked due to the risk of patients wandering away. There are varying numbers of staff on shift; the unit is part of a central rostering system, although there is a core group of staff based on the unit. There are two household staff. There is a process of induction for staff. Visiting times are flexible and are actively encouraged. There are set meal times and there is availability of snacks and drinks throughout the day.

SERVICE USER INVOLVEMENT

The unit is developing its own information booklet. Information on patients' rights is given to the families. There is a HSE-wide complaints policy. The staff try to ascertain relatives' opinions and views of the service and link with the community liaison nurse.

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RECORDS

The records do not always contain the patient's name and ID on all the pages. Some of the files were untidy, though entries were signed and dated. The files contain a treatment plan. It was reported that the consultant psychiatrist attended the ward weekly. Any reviews of patients were documented in the clinical files. Nursing files were neat and tidy, contained patient's name and number and were appropriately signed. It was noted that some of the care plans were in need of review. Drug cards were all appropriately signed and dated. The files of the patients who were on Temporary order were appropriate.

ENVIRONMENT

This was a 24-bed ward in a psychiatric hospital. There was evidence of ongoing maintenance and there was disabled access. The corridors were long and safe and suitable for patients who wander. There were seats positioned in the corridors to enable people to rest. There was a visitors' area that was well furnished and popular with family members. The garden facility, as already stated, was an excellent facility. The bedroom areas consisted of dormitories and two single rooms. One of the dormitories was mixed and the staff do all they can to ensure privacy and dignity although it is not a satisfactory arrangement. There were two single rooms. The dormitories were large and there were curtains around the beds. Patients had their own wardrobe spaces and all had their own clothes, which were clearly marked. The toilets and bathrooms were in very good condition. The décor was excellent. There was free access for those people who were able to go out themselves. The dining area was appropriate for one sitting. There was self-service and once again décor was excellent. The lounge area had a very high standard of furniture, it was extremely comfortable and the staff should be commended for the layout and style of furniture purchased. The nurses' station was central within the ward, it was confidential, there was space for report writing; it was accessible and had a telephone and IT system. The clinical room was appropriate and contained all the medical equipment needed.

ST. CLARE'S WARD

Date of inspection: 5th September 2005

Number of beds: 24 integrated (8 female, 16 male)

DESCRIPTION

This is a unit with 24 beds which was described as providing rehabilitation. It is an open unit and on the day of inspection there were thirteen male patients and six female.

REFERRAL

The source of referral to the unit is the Department of Psychiatry in Waterford Regional Hospital and St. Enda's Ward in St. Otteran's Hospital. It is emphasised by the CNM2 that this is a very static population and that 80% of the patients are long stay. The referral process consists of contact being made between a consultant psychiatrist and the consultant psychiatrist with responsibility for the ward, who then make decisions regarding transfer.

PROCESS OF ADMISSION

Occasionally patients with a moderate intellectual disability are transferred to the unit. Occasionally people are transferred for respite care. Once a decision has been made to transfer, the patient visits the unit. Once they are formally transferred they are orientated to the unit by the nursing staff. A key worker is allocated and care plans drawn up. The NCHD is responsible for the physical well-being of the patient and an ongoing collateral history is taken. The treatment plan is explained to the patient verbally and the initial treatment plan is documented in the nursing notes. Family contact is encouraged and the consultant psychiatrist reviews each patient weekly. Following last year's inspection the unit has introduced a new key worker system. Nursing staff are allocated to groups of patients and they are responsible for their care plans. It was reported that this is a problem due to the staff being part of a central roster system and frequently changing wards.

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CARE PLAN

Care plans are nurse led and devised by a key worker. Goals and objectives are identified and the care plans are reviewed on a weekly basis. There is no formal process for involving the patient in the care plan. The usual route of discharge from this ward is to the Glendower Training Centre on site. This is a medium support hostel and is part of the rehabilitation process. However it was reported that the staff on this ward feel that patients need to be more prepared before they are transferred to Glendower. Some patients are discharged home or to other community facilities.

NURSING PROCESS

The Orem Peplau combined nursing model is in use on the ward. The nursing management decide what model is used and the staff feel that this model is appropriate to patients' needs. The care plan process has been agreed as part of the Regional Syllabus for Student Nurse Training. There are no formal risk assessments carried out. Staff are identified by uniform.

ACCESS TO THERAPY

There is occupational therapy on site in the hospital although on the inspection of this area it was noted that the majority of activity undertaken in occupational therapy is of an industrial therapy nature. The psychologists and social workers are available via a referral system as well as an addiction counsellor. It was reported that there are no cognitive behavioural therapy counsellors. There is one consultant psychiatrist responsible for the ward who carries out a weekly review. Patients also have access to a chiropodist and there is a dental outpatient clinic on the hospital site.

ACCESS TO THERAPEUTIC PROGRAMMES

There appears to be little therapeutic activity in place on this ward. Patients are encouraged to attend the occupational therapy department, the WAVE project in town, or have jobs in St. Otteran's. As already stated, the majority of the patients are deemed to be

long-stay continuing care patients. There needs to be some thought as to whether this ward can actively be a rehabilitation ward and if this is the case then a more appropriate group of patients needs to be placed on the ward, or in a community setting. The activities that are available are a relaxation group and some outings; a number of patients have chores and attend to their personal hygiene.

CLINICAL RISK MANAGEMENT

It was reported that the local policies within the hospital are currently in draft format and are awaiting ratification from the Director of Nursing and Clinical Director. There was a regional policy on clinical risk management available. The staff receive training in control and restraint techniques, which incorporates breakaway and de-escalation techniques. All staff are trained in cardio-pulmonary resuscitation and other mandatory training. Serious incidents are reported on appropriate forms and sent to the risk management department.

UNIT MANAGEMENT

Patients are not transferred temporarily or long term to other units due to pressures on beds. The patients are allowed off the ward unaccompanied but are asked to inform staff where they are going and when they will return. The front door to the unit is open but there are a number of doors locked within the unit. The dining room, kitchen and some of the dormitories are locked during the day. There are only three staff on duty during the day, which is insufficient to promote a rehabilitation philosophy and programme. There is only one male staff on duty at night, which is inappropriate due to the fact that there are a number of female patients on this unit. Staff are sent to this ward via a central rostering system, although there are some core staff.

It was reported that there are three people who are appropriate to move on to the next level of rehabilitation programme but it was also reported that there are only five people of the current patient group who are in any way active in rehabilitation programmes. Maintenance is carried out via the Waterford Regional Hospital and it was reported as a not very efficient system. Visiting times are flexible.

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Meal times are at set times and there are snacks and drinks available during the day. A number of patients on the unit attend the café within the hospital, which has recently been closed on Sundays, and this was noted to cause distress to the patient group and families. It was also reported that there is no access to a drinking water machine on the unit but patients can have mineral water on request.

SERVICE USER INVOLVEMENT

There is some information available on treatment and therapies and patients' rights. There is a complaints policy in place. The unit has recently introduced a community meeting which is held monthly and minutes of this meeting are kept. The staff interviewed were unsure if the Irish Advocacy Network accessed the ward.

RECORDS

The medical files were legible and tidy and had the patient's name on each page. It was reported that the consultant psychiatrist reviews the patients weekly. Any reviews of patients were documented in the clinical files. The nursing files were legible and contained appropriate care plans which were regularly evaluated. The medication cards were appropriately signed and dated although it was noted that some of the cards needed rewriting.

ENVIRONMENT

This was a 24-bed unit within a psychiatric hospital. It appeared to be in reasonably good décor and had appropriate light and ventilation. It was reported that the structural fabric of the unit is poor and toilet facilities are inadequate. There were information boards containing up-to-date information. There was a dedicated visitors' area and front doors were open. The bedroom areas contained dormitories and some of the dormitories did not have curtains around the beds. There were no single rooms and the number of clients in each dormitory ranged from four to eight. Each patient had their own wardrobe space, some of which were new. Toilets and bathrooms were a good standard with free access and gender specific but

insufficient in numbers. The dining area had sufficient space for all at one sitting though it was locked at the time of inspection and this was reported to be for safety reasons. The lounge area was large but divided. It had a dedicated TV area. It was reported by one of the patients that the video was broken and staff said they would get this sorted out. The nursing station featured centrally within the main corridor of the ward. It had appropriate space for report writing, and it was confidential and accessible. There was a telephone and IT system and an alarm system in place. The clinical room was appropriately furnished and contained all the appropriate medical equipment. There was adequate storage within the unit.

ST ENDA'S WARD

Date of inspection: 5th September 2005

Number of beds: 16 male

DESCRIPTION

St. Enda's Ward is located on the ground floor of St. Otteran's Hospital in Waterford. It is described as a "semi-secure" unit and on the day of inspection the door was locked. However, it was stated that the door is usually open. The age range of patients is from 28 to 76 years. There were four patients on Temporary status on the day of inspection. The remainder of the patients were Voluntary status.

REFERRAL

Patients are referred to the ward from St. Claire's Ward which is termed a rehabilitation ward, from the Department of Psychiatry in Waterford Regional Hospital, and directly from the community through the A&E department. All referrals to the ward are through the consultant psychiatrist with responsibility for the ward.

PROCESS OF ADMISSION

All patients admitted to the ward are assessed by the NCHD and a treatment plan documented in the clinical file. The patients are not routinely nursed in their night clothes.

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CARE PLAN

There is no multidisciplinary care plan. Patients are reviewed where necessary by the consultant psychiatrist twice a week and a treatment plan documented. There are no multidisciplinary team meetings held on the ward. All discharges from the ward are to St. Claire's Ward, the Department of Psychiatry, or home. A nursing transfer form is completed.

NURSING PROCESS

The nursing model available on the ward is the Peplau. All patients had a nursing care plan initiated. However in the files inspected these had not been reviewed for more than six months. Nursing progress notes were completed daily. There is no primary nurse system. Nurses and patients are divided into teams for the purpose of responsibility.

ACCESS TO THERAPY

There is no psychologist, social worker or occupational therapist input to this ward. Patients are referred to a social worker or psychologist through the local day hospital if necessary.

The consultant psychiatrist reviews patients twice a week and the NCHD is available daily. There are no difficulties accessing surgical and medical care for patients.

ACCESS TO THERAPEUTIC PROGRAMMES

There are no activities carried out on the ward. Some patients are allowed out to the activation unit and occupational therapy. There are no needs-based activities available.

SECLUSION

Seclusion is carried out on the ward. There is a draft seclusion policy, a seclusion register and a 15-minute checklist. The seclusion room was bleak. The window did not have safety glass and it was easy to climb onto the window-ledge. There was a blind on the

window locked in the down position to prevent this happening, which means that when it is occupied, the room has no daylight. There was a thin mattress on the floor. There was a peephole in the door and there was CCTV in operation in the room due to a blind spot. Lights were controlled from outside the room. One patient was sleeping in the room (unlocked) at night at the time of the inspection.

CLINICAL RISK MANAGEMENT

Draft policies were available on the ward. There were policies on searching patients, the management of violence and on medication. There was a pinpoint alarm system in place. All staff on the ward have been trained in breakaway techniques and in control and restraint techniques. Some staff have been trained in cardio-pulmonary resuscitation. Serious incidents are recorded and passed on to management.

UNIT MANAGEMENT

There are no transfers to the ward due to bed shortages in other units. There are four nursing staff on duty during the day and two staff on duty at night. There are two household staff on duty. There is open visiting time and meals are at 0830h., 1230h, and 1630h. with tea and biscuits at 1900h. There are problems obtaining urgent maintenance.

SERVICE USER INVOLVEMENT

There was a notice board with some information. There is no access to the Irish Advocacy Network. All patients spoken to complained about the quality of the food. They also complained that there was nothing to do on the ward. Two patients complained that there was no access to counselling.

RECORDS

The clinical records were of good standard. They were neat and contained up-to-date entries. The signatures were legible but no titles of personnel were used. The medication sheets were legible and generic names of drugs were used. There was no separate space for PRN medication.

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ENVIRONMENT

The ward was in very poor condition and unfit for habitation. There was paint and plaster peeling off walls and holes in some of the bedroom doors. Curtains were falling down in some areas. The corridors were painted a vivid orange and yellow. There was a large bleak day room with four uncomfortable chairs and a TV, a broken exercise bike and a small table and nothing else. Next to this was a large smoking room with six or seven seats, a radio and a TV and a pool table. The patients were sitting around the room. There were no activities going on in the ward. There was a large quiet room with two chairs and nothing else. There were few decorations and there was no attempt to make it homely. The dining room was painted dark green and the paint was peeling in some areas. There was no visitors' room.

There was a corridor of single bedrooms, which were in very poor condition. There were wardrobes in each room. Patients had few personal possessions, apart from one or two of the younger patients. The dormitories were in dreadful condition. They were bare, had no privacy or curtains around the beds. The beds were unmade and clothes were spilling out of cupboards. Patients had individual wardrobes. The night nursing station had no desk. The toilets in the night area were closed off due to an overflowing urinal. All the toilets on the ward had plaster and paint peeling off the wall. Tiling had fallen off and there was damp around the windows and water on the floor. There was a shower room that had no heating and therefore could not be used in the Winter. There was a courtyard that was fenced in. There was a broken drain-pipe and water gushed into the courtyard when the taps were run in the patients' washroom.

It was stated that St. Enda's ward will close and a house on the grounds will be converted to accommodate the patients.

ST JOSEPH'S WARD

Date of inspection: 6th September 2005

Number of beds: 34 beds (17 male, 17 female)

DESCRIPTION

St. Joseph's ward is a single-storey stand-alone unit in the grounds of St. Otteran's Hospital. It provides continuing care to patients between the ages of 50 and 80 years. Four male patients need full nursing care. There is one patient on Temporary status. The ward is locked due to the risk of some patients wandering away.

REFERRAL

Patients are referred to the ward from other wards in the hospital, from the Department of Psychiatry in Waterford Regional Hospital and directly from hostels. All referrals are through the consultant psychiatrist with responsibility for the ward.

PROCESS OF ADMISSION

All patients admitted to the ward are assessed by the NCHD and a treatment plan documented in the clinical file. A number of patients are admitted for social reasons such as death of carers or inability to continue living in a hostel due to physical problems.

CARE PLAN

There is no multidisciplinary care plan. Patients are reviewed where necessary by the consultant psychiatrist twice a week and a treatment plan documented. There are no multidisciplinary team meetings held on the ward.

NURSING PROCESS

The nursing model available on the ward is the Orem Peplau model. The staff feel that this is appropriate to the needs of the patients. All patients had a nursing care plan initiated. Nursing progress notes

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were completed daily. There is no primary nurse system. Nurses and patients are divided into teams for the purpose of responsibility.

ACCESS TO THERAPY

There is no psychology, social work or occupational therapy input to this ward. Patients are referred to a social worker or psychologist through the local day hospital if necessary. There is one patient attending a psychologist at present. The consultant psychiatrist reviews patients once a week and the NCHD is available daily. There are no difficulties accessing surgical and medical care for patients.

ACCESS TO THERAPEUTIC PROGRAMMES

There is an activation timetable displayed, however there are no activities carried out on the ward. Three patients go to the activation unit. There are no needs-based activities available. The reasons given were lack of time and lack of space.

SECLUSION

Seclusion is not carried out on this ward.

CLINICAL RISK MANAGEMENT

All staff on the ward have been trained in breakaway techniques, control and restraint techniques and cardio-pulmonary resuscitation. Draft policies were available on the ward. There were policies on searching patients, the management of violence and on medication. There was a pinpoint alarm system in place. Serious incidents are recorded and passed onto management. Feedback is given by the Health and Safety Advisor if necessary.

UNIT MANAGEMENT

There are no transfers to the ward due to bed shortages in other units. There is no waiting list for the ward and there are no patients awaiting other accommodation. There are six nursing staff on duty during the day and two nursing staff on duty at

night. Staffing is by central rostering and nurses know where they will be located two weeks in advance. There are three household staff on duty during the week and two on duty at weekends. There is open visiting time. Meals are at 0830h., 1230h., and 1630h. with tea and biscuits at 1900h. Bedtimes are mainly at patients' choice of time, with most being in bed by 2100h. Patients have their own clothes and are allowed off the ward. There is no CCTV in operation. There are problems obtaining urgent maintenance.

SERVICE USER INVOLVEMENT

There was a notice board with some information. There was no information leaflet available. There is no access to the Irish Advocacy Network. There was a complaints policy available and notice about making complaints. One patient spoke of being bored as there was nothing to do on the ward.

RECORDS

The clinical records were untidy but they contained up-to-date entries. The signatures were legible though no titles of personnel were used. The medication sheets were legible and some generic names of drugs were used.

ENVIRONMENT

The unit had a pleasant entrance hall. It was divided into male and female wings with a common dining room. On the male side, there was a day room with a smoking room beside it, both were in need of painting. There was a disabled toilet off the day room which was in good condition. There was a 17-bed male dormitory. Two patients were in bed with PEG (tube) feeding. There were no curtains around the beds. Each patient had an individual wardrobe. The toilets and bathroom off the dormitory were being renovated. The dining room was large and had a TV and radio. There was a pharmacy and clinic room. The female day room was pleasant and again there was a smoking room off the day room. The female dormitory had 16 beds plus one single room. There were no curtains around the beds. The bathroom and toilets needed tiling.

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ST. MONICA'S WARD

Date of inspection: 6th September 2005

Number of beds: 34 integrated

DESCRIPTION

This is a unit with 34 beds providing continuing care and supportive rehabilitation for a population of people with serious and persistent mental illness (the majority of whom are elderly, some physically disabled). It is an open unit and on the day of inspection there were seven male patients and nineteen female patients.

REFERRAL TO UNIT

This unit accepts transfers from other wards in the hospital and the Department of Psychiatry at Waterford Regional Hospital. On occasions patients are admitted from community facilities. The process of referral is from ward to ward. Physical examinations are undertaken by the NCHD and the person making the decision to admit is the consultant psychiatrist. It is difficult for the staff to communicate with the patients regarding their treatment plan due to the profound nature of their illness. Family contact is encouraged where possible. It was reported that the consultant psychiatrist reviews patients weekly and the initial treatment plan is documented in the notes. There is no identified key worker system.

CARE PLAN

Care plans are nurse led, in consultation with the medical staff. It is reported that physical needs are priority and the goals and objectives identified regarding a patient's physical well-being. The care plan is reviewed monthly.

NURSING PROCESS

The unit uses the combined Orem Peplau nursing model. This is regarded as appropriate to the needs of the patients but it is felt that a model more appropriate to care of the elderly should be introduced. The current care plans are implemented

by the nursing team. It is also noted that there is an individual assessment carried out regarding the requirements for lifting and handling.

ACCESS TO THERAPY

There is access to a psychologist, social worker and occupational therapist on request where clinically indicated. There is one consultant psychiatrist responsible for the unit. The consultant psychiatrist visits weekly and is contactable in between. Physical well-being is maintained by the NCHD in conjunction with the regional hospital. There is access to a chiropodist. There are two patients who require PEG (tube) feeding. Currently there is no funding available for the provision of a dietetic consultancy service to the hospital. The two patients are too physically ill to be transferred for any appointments.

ACCESS TO THERAPEUTIC PROGRAMMES

It was stressed that the emphasis on the ward is to maintain people's physical well-being. It was reported however, that there are other activities of care such as some reminiscence therapy, music, spiritual, videos which a number of patients enjoyed watching on TV. There were walks in the grounds, home visits and a number of patients liked to visit the café in the hospital.

CLINICAL RISK MANAGEMENT

There is a policy on risk management available. It was reported that this ward has security at night due to some previous problems with people coming into the hospital grounds. A number of the patients have cot sides on their beds and it was reported that this is documented in the notes. Some of the patients were in bed at the time of the inspection, which was mid-way through the afternoon but it was explained that a number of them were on bed rest and some patients are confined to bed due to the physical nature of their illness. More care is given to the patients who are in bed and the staff are fully aware of the need for pressure area care. Staff are trained in control and restraint techniques, which incorporates de-escalation and breakaway techniques. It would

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appear there is very little violence or aggression on the unit. It was reported that staff are in the process of receiving cardio-pulmonary resuscitation training and also venepuncture and manual handling. The serious incidents are recorded on appropriate forms and sent to risk management. Occupational health is sometimes involved and feedback is given.

UNIT MANAGEMENT

The male patients are frequently off the ward on their own. They attend the café within the hospital and quite often sit outside the ward. Most of the female patients have to be accompanied, although one female leaves the ward unaccompanied. The door is open. The staff are part of a central rostering system although there are some core staff. There are three household staff and the dress code is uniform. People are asked to avoid meal times when visiting, otherwise arrangements are flexible. Meals are at set times and there are snacks and drinks available during the day and it was stated there is a café on site which being closed on a Sunday causes some problems for patients.

SERVICE USER INVOLVEMENT

There is some information on treatments and therapies and the staff are closely in contact with the Temporary patient's relatives.

RECORDS

The patient's name and number was not always identifiable on the pages of the file. Some of the files were quite untidy. There was evidence of psychiatric reviews and documentation regarding the patients' physical state. The nursing files contained care plans that pertained to patients' physical well-being and were regularly evaluated. Drug cards were signed and dated appropriately and all were recently rewritten. The chart of the person who has been involuntarily detained was reviewed and is appropriate. The team should be commended for the amount of contact they have made with this patient's family.

ENVIRONMENT

This was a large 34-bed unit within the grounds of St. Otteran's hospital. There was an ongoing maintenance programme although it was reported there were difficulties with keeping the unit updated. It had disabled access and it was noted on the day of the inspection to be a warm unit. The corridors were long but very nicely furnished and there was an emphasis throughout the unit that they try to make it as homely an environment as possible. There was access to a garden. The bedroom areas were large dormitories and there were some single rooms for women. There were curtains around the beds in the dormitories and everybody had their own wardrobe space and their own clothes and shoes. Toilets and bathrooms were a good standard of décor with free access to these but most people had to be assisted when going to the toilet. There were specific bathing times and the bathrooms and toilets were gender specific.

The dining room had space for all patients at one sitting and the majority of the patients had to be fed. The lounge areas contained comfortable seating and there was a separate area for the male patients who were more ambulant and self-sufficient. The nurses' station was central to the ward and there was confidential space for report writing; it was accessible and contained telephone and IT system. The clinical room had all the appropriate equipment needed. The general feeling on the ward was that it was a very comfortable and homely environment and a balance has been obtained between providing a caring service with a homely environment.

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WATERFORD

ARD NA DÉISE RESIDENCE, WATERFORD

Date of inspection: 6th September 2005

Number of beds: 14 integrated, 9 male, 5 female

DESCRIPTION

Ard na Déise is a three-storey residence in its own grounds about two miles from Waterford city centre. A former GP's residence, the residence is owned by the HSE and was opened in 1993. A bus service links the residence to the city centre. It provides 24-hour care to residents with enduring mental health needs, who range in age from 31 to 75 years. There is no rehabilitation team in this catchment area. One consultant psychiatrist has admitting rights to the residence.

REFERRAL

Referrals normally come from St. Claire's ward in St. Otteran's hospital. There is no assessment by residence staff prior to admission but discussion takes place between the consultant psychiatrist and the unit manager. The NCHD undertakes a full psychiatric and physical assessment and a nursing transfer form is forwarded from the ward.

PROCESS OF ADMISSION

There is no site specific admission policy but prospective residents need to be mobile, over 18 years, have enduring mental health problems and require 24 hour support. The new resident is allocated a key worker, who introduces the resident to the residence. The NCHD reviews the resident within a week of admission. There has been one admission to the residence in each of the past three years.

CARE PLAN

There is no multidisciplinary care plan in place. The key worker completes a social functioning profile on

the new resident and formulates a nursing care plan. Objectives are set and the care plan is reviewed every two months or as needs dictate. The key worker liaises with the family or carers if appropriate. One resident is currently awaiting discharge to independent accommodation. Prior to discharge, the key worker links with relevant professionals in the community.

NURSING PROCESS

The Orem and Peplau model of nursing is in use. There is no formal risk assessment process but individual risks are identified in residents' care plans. Nursing staff do not wear uniforms or wear identification badges as they feel that this would militate against the creation of a homely atmosphere.

REHABILITATION TEAM

There is no rehabilitation team. The consultant psychiatrist visits on a fortnightly basis. Residents are reviewed by the NCHD every six months. All residents are registered with local GPs.

INVOLVEMENT IN REHABILITATION PROGRAMMES

Social skills and life skills programmes are organised in the residence. Some residents are involved in programmes off site. Two residents attend the National Learning Network, one attends the Waterford Employment Service and one is involved in voluntary work on a five day basis. Four residents attend a workshop in St. Otteran's hospital and one attends the day hospital in Brook house.

UNIT MANAGEMENT

There are no temporary transfers to or from the residence. The residence is staffed by two nurses in the daytime, one in the evening and one at night. There is one household staff member in the daytime. There is unit rostering in the residence. There is no formal waiting list. There are clinical risk management policies and a method of reporting and auditing serious incidents. Staff have received training

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in control and restraint, health and safety and in a range of other issues but have received no training in rehabilitation or managing a community residence.

ETHOS

There is an induction booklet for students and a unit profile is available. The aim of the unit is to create an open, homely atmosphere for residents and to encourage independence, community participation and de-institutionalisation. Formal policies and procedures are generic. There are no links with other residences with a view to developing specific policies for the residences.

HOUSE RULES

There are many centralised policies regarding rules concerning health and safety. Other rules of the house are formulated by staff and reviewed on a monthly basis. Visiting times are flexible and residents do not have front door keys. Residents are not required to check in and out but are asked to let staff know if they intend staying out late. Bathroom and bedroom doors are lockable. Some of the residents are retired and choose to remain indoors most of the day. Residents have free access to the kitchen for snacks and drinks. Lunch is provided from the hospital but residents are involved in preparing the tea and in meal planning and shopping. Residents are not allowed smoke in their bedrooms or have visitors stay overnight. They are allowed lie in at weekends. An inventory of residents' belongings is made on admission but no record is kept thereafter. All social welfare books are kept in the nurses' office and are cashed by nursing staff. Residents are given a set amount weekly. Some residents purchase their own clothes. All have access to the utility room. Public transport is available. There are some shops and facilities within walking distance. Several residents access GPs, shops and other community facilities unaided.

SERVICE USER INVOLVEMENT

There is a notice board which gives details of key workers. A site specific mission statement and

philosophy is posted. Residents are given verbal information on treatment and therapies and the key worker advises regarding national health initiatives. There are also some information leaflets available. There is a complaints' policy but no formal method of seeking residents' opinions on the service and no community meetings.

RECORDS

The medical files were legible with all entries signed and dated. Titles of personnel were not always used. There were no progress reports from occupational therapists, social workers or psychologists. The consultant psychiatrist reviewed residents every six to twelve months with more frequent reviews by the NCHD. Nursing notes were generally in good order. Titles of personnel were not always used. A signature bank was available. Medication records were also in good order with the exception that the discontinuation of medication was not always signed.

ENVIRONMENT

The ground floor comprised a lounge, dining room, kitchen utility room and toilet. On the first floor there were four two-bed rooms a single room, a three-bed room, two bathrooms with WCs and three showers. On the second floor, there were two single bedrooms and two WCs. The residence was clean but the décor was not adequate and a maintenance programme needed to be put in place. The building was not accessible or life time adaptable and therefore not suitable for residents with mobility problems. The residence was private and had an extensive garden area.

GLENDOWER RESIDENCE

Date of inspection: No date given

Number of beds: 10

Glendower medium support residence is located on the grounds of St. Otteran's Hospital. It is a 10-bed unit. Glendower is the headquarters for the supported accommodation in the Waterford catchment. There are four nursing staff on duty during the day and they are responsible for 47 clients

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living in supported accommodation and nine group homes in Waterford. There is also a clerical officer on duty five mornings a week.

Glendower opened in 1984. Referrals come from the Department of Psychiatry at Waterford General Hospital, St. Otteran's Hospital and the community. Referrals are through the consultant psychiatrist with responsibility for the residence. Referrals are not assessed by the nursing staff of the residence prior to the client's admission. Information is given to the patient prior to their transfer. It was stated that occasionally residents have to be moved prior to completing their programme to make room for an urgent referral. There are scheduled team meetings one day a week attended by medical and nursing staff. There are no psychologists, social workers or occupational therapists with input into the unit.

Each resident has a care plan that has been devised by the nursing staff. This is based on an assessment over a month and uses the social functioning questionnaire. Each care plan is regularly reviewed. Each client in all the community residences has a nurse key worker. There is a broad age range of residents in the supported accommodation.

Many residents attend Waterford Adult Vocational Training (WAVE) or the National Learning Network. There are difficulties in residents progressing to open or supported employment despite efforts of staff. Most discharges from residence or group homes is to Focus Ireland accommodation, home, independent living or back to St. Otteran's Hospital.

Glendower Residence is a pleasant homely environment with shared bedrooms and one single room. Residents cook their own breakfasts and tea and the hospital provides dinner. The sitting areas and dining room are comfortable. However the residence requires repainting and re-wallpapering.

ACTIVATION UNIT, ST. OTTERAN'S HOSPITAL

This is a single-storey building at the back of the grounds of St. Otteran's Hospital. It was originally an industrial therapy unit. It has two very large rooms and a dining room, kitchen, laundry, toilets and nurses office. The whole building is in need of redecorating. The main activities are fence-making

for a local contractor, piece work from a local factory and laundry for the hospital. Patients receive up to €25 every two weeks for the piece work. There are also other activities such as basketball and table tennis.

There is one staff nurse in the unit. There are no occupational therapists or any other therapists with input to the activation unit, although this is called an "occupational therapy unit".

Clients attending the unit come from wards in the hospital, supported accommodation, group homes, and their own homes. Therefore the unit operates as a day centre as well as an activation unit and industrial therapy unit.

SPRINGMOUNT HOUSE, DUNGARVAN

Date of inspection: 8th September 2005

Number of beds: 13 integrated (5 male, 8 female)

DESCRIPTION

Springmount House is a two-storey residence in the grounds of St. Joseph's hospital, Dungarvan, Co. Waterford. It is within walking distance of the town centre. A former residence of a religious community, the residence is owned by the HSE and was opened in 1997. It provides 24-hour care to residents with enduring mental health needs, who were originally from the West Waterford area and who range in age from 38 to 78 years. Two of the residents are Wards of Court. There is no rehabilitation team in the catchment area. One consultant psychiatrist has clinical responsibility for the care of residents in the residence.

REFERRAL

Referrals normally come from St. Claire's ward in St. Otteran's hospital. Other admissions have come from low support homes in the area. Prospective residents are all assessed prior to admission. The consultant psychiatrist makes the decision to admit. There is no assessment by residence staff prior to admission but discussion takes place between the consultant psychiatrist and the unit manager. If a person is being

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transferred from St. Otteran's Hospital or from the Department of Psychiatry, Waterford Regional Hospital, a nursing transfer form is forwarded from the ward.

PROCESS OF ADMISSION

There is no site-specific admission policy but prospective residents need to be mobile, over 18 years, have enduring mental health problems and require 24-hour support. Admissions are generally for rehabilitation. Some admissions are due to social crisis. The new resident is allocated a key worker, who introduces the resident to the residence. The consultant psychiatrist reviews the resident within a week of admission.

CARE PLAN

There was no evidence of multidisciplinary care planning in the residence. The key worker completes a coping skills assessment on the new resident and formulates a nursing care plan. Objectives are set and the care plan is reviewed every month, or more frequently if necessary. The key worker liaises with the family or carers if appropriate. Prior to discharge, the key worker links with relevant professionals in the community. Since 1997, 26 residents have lived in this unit. Five have returned to hospital due to mobility problems. Two have died. One person was discharged within the past year.

NURSING PROCESS

The Orem Peplau model of nursing is in use. There is no formal risk assessment process but individual risks are identified in residents' care plans. Nursing staff do not wear uniforms or identification badges.

REHABILITATION TEAM

There is no rehabilitation team. The consultant psychiatrist visits weekly. An occupational therapist, social worker and psychologist are available from the Waterford mental health services. Voluntary organisations are involved with particular residents. All residents are registered with local GPs.

INVOLVEMENT IN REHABILITATION PROGRAMMES

The residence staff organise a range of programmes to suit the needs of individual residents. These include anxiety management, cooking and exercise. Some residents attend the day centre which is located next door. Three residents attend Sonas, an organisation which focuses on vocational training and personal development. Outings for residents are organised each Wednesday, and this sometimes involves visits to residents' areas of origin.

UNIT MANAGEMENT

There are no temporary transfers to or from the residence. The residence is staffed by two nurses in the daytime, one in the evening and one at night. There is one household staff member in the daytime. There is unit rostering in the residence. There is no formal waiting list. There are clinical risk management policies and a method of reporting and auditing serious incidents. Staff have received training in control and restraint, health and safety and in a range of other issues.

ETHOS

The aim of the unit is to create homely atmosphere for residents and to encourage independence and community participation. The emphasis of care is to respond to the needs of the individual and to improve the quality of residents' lives. Formal policies and procedures are generic. There are no links with other residences with a view to developing specific policies for the residences.

HOUSE RULES

There are many centralised policies regarding rules concerning health and safety. Visiting times are flexible and residents do not have front door keys. Residents are encouraged to leave the residence unsupervised but are asked to let staff know if they intend staying out late. Bathroom and bedroom doors are lockable. Some of the residents are retired and residents are not required to be out of the residence during the day. Residents have free access to the kitchen for snacks and drinks. Lunch is

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provided from the hospital but residents are involved in preparing the tea and in meal planning and shopping. Residents are not allowed to smoke in their bedrooms or to have visitors stay overnight. They are allowed lie in at weekends. Residents' belongings are not listed but valuables may be left for safekeeping in the safe. Each of the residents has a bank account and social welfare payments are paid by direct payment. Residents receive a monthly statement of account and are encouraged to have independent access to their accounts if possible. Some residents purchase their own clothes. All have access to the utility room but a rota is devised. Public transport is not available but some residents use taxis. There are some shops and facilities within walking distance. Six of the residents access GPs, shops and other community facilities unaided. Others require staff support.

SERVICE USER INVOLVEMENT

Residents are involved in the formulation of their care plans. Residents are given verbal information on treatment and therapies and the key worker advises regarding national health initiatives and the rights of residents. There are also some information leaflets available. There is a complaints policy and a community meeting is held once a fortnight to discuss issues relating to life in Springmount House. There has been one visit from an advocate.

RECORDS

The medical files were legible with all entries signed and dated. Titles of personnel were not always used. It was reported that the consultant psychiatrist reviewed residents every six to twelve months. However, all residents are scheduled for outpatient appointments at the outpatient clinic, which is adjacent to the residence, and the frequency of review depends on clinical need. Nursing notes were generally in good order. Titles of personnel were not always used. A signature bank was available. Medication records were also in good order.

ENVIRONMENT

The ground floor comprised a large lounge, dining room, kitchen, utility room and toilet and nursing office. The bedrooms, which were all single rooms, were located on the first floor. Parts of the residence had been painted during the past year. The residence was clean and well furnished. The building was not accessible or lifetime adaptable and therefore not suitable for residents with mobility problems. The residence was private and had a well-maintained garden area, which was sometimes used by patients and visitors to St. Joseph's Hospital.

CLONMEL GENERAL HOSPITAL

ST. MICHAEL'S ADMISSION UNIT

Date of inspection: 30 August 2005

Number of beds: 50 integrated, 25 male, 25 female

DESCRIPTION

St. Michael's admission unit is an open standalone unit in the grounds of South Tipperary General Hospital. It is a single-storey building with separate male and female wings. There are integrated dining areas and activity rooms. There were seven male patients and three female patients on Temporary status on the day of inspection.

REFERRAL

Referrals to unit are mainly through GPs, A&E and outpatient clinics.

PROCESS OF ADMISSION

All patients have a physical and psychiatric assessment on admission to the unit. An initial treatment plan is documented in the chart. Children under 16 years have occasionally been admitted. There is an admission policy available. Patients are not admitted for the purpose of detoxification. The decision to admit the patient is taken by the NCHD, who contacts the consultant psychiatrist if necessary. All Temporary forms are signed by the consultant psychiatrist.

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CARE PLAN

There is no multidisciplinary care planning. There are treatment plans outlined in the chart. There is a nursing care plan. There are weekly team meetings for all sectors.

NURSING PROCESS

There is a primary and associate nurse system in operation on the unit, based on sectors displayed in the unit.

ACCESS TO THERAPY

There is no psychologist currently in the service. Access to a social worker is through referrals. There are no occupational therapists within the general adult mental health service. There is access to addiction services through the day hospital service in Clonmel.

ACCESS TO THERAPEUTIC PROGRAMMES

Activities on the unit are provided by nursing staff and there is an activity room. Art therapy is available and there are relaxation groups. There are no needs-based activities. A training kitchen is currently being constructed.

ECT

There was a dedicated ECT suite. It contained a waiting room, a treatment room and a recovery room. An ECT register was available. ECT is available twice a week. There is a consultant psychiatrist and dedicated nurse with responsibility for ECT. There is a consent form, pre-ECT checklist and post-ECT checklist.

SECLUSION

The seclusion room is located in the male observation area. At the time of the inspection it was occupied. It is monitored by CCTV and has external controls for

lights. It has an extractor fan, safety mattress and a sports finish on the wall. It has access to a toilet and shower. The seclusion room is used as a bedroom on occasion. The seclusion register was signed. There was a 15-minute checklist. Seclusion was documented in the clinical file.

CLINICAL RISK MANAGEMENT

There is a policy of giving medication without consent. There are four levels of observation in use on the unit: special nursing, 15-minute observation, 30-minute observation and hourly observation. Observation levels are recorded on a separate form and signed by the medical and nursing staff. There is a pinpoint alarm system in operation. CCTV is in use on the unit.

UNIT MANAGEMENT

There is a full-time unit clerk. Phlebotomy is carried out by nursing staff. There is a daily meeting with all multidisciplinary staff and teams in St. Michael's. There are no patients currently waiting for accommodation on the male side of the unit. The unit runs at approximately 99% occupancy. Male patients are transferred to St. John's unit (a locked long-stay unit in St. Luke's Psychiatric Hospital) for disturbed behaviour or if there are bed shortages. Female patients may be transferred to St. Bridget's unit for similar reasons. On occasion, first admissions are sometimes initially admitted to St. John's unit. There are four or five nursing staff on duty during the day on both sides of the unit and two staff on duty each side at night. In total there are five household staff on duty during the day.

SERVICE USER INVOLVEMENT

There were information leaflets available. The complaints procedure was displayed in the unit. An Irish Advocacy Network representative visited the unit every two weeks.

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RECORDS

There was a new patient assessment sheet in the clinical file. The files were neat and had up-to-date entries. The signatures were illegible and no titles of personnel were recorded. The medication sheets were signed and dated. However, again the signatures were illegible.

ENVIRONMENT

The male side of the admission unit has recently been renovated. New floorings have been put down, the unit has been painted, and a new observation area constructed at the end of the unit. A courtyard is currently being constructed. There is a reception area at the front of the unit. There is a comfortable TV lounge and a quiet room. The dining room is newly decorated. There is a pharmacy and an activity room. There is a conference room and offices for psychologists although there is no psychologist currently in the service. There is an interview room.

The new observation area has five beds and a smoking room. The area is monitored by CCTV although there are no notices informing patients of this. There are dedicated toilets, but the doors open inwards only. There are five single bedrooms, two double rooms which are en-suite, one 6-bed dormitory and one 5-bed dormitory on the male side. All the dormitories and toilets were open. There were five showers. On the female side of the unit there were three single rooms, two double rooms and two 6-bed rooms. There was a 5-bed observation area and a seclusion room in the female unit.

ST. LUKE'S HOSPITAL, CLONMEL

ST. BRIDGET'S WARD

Date of inspection: 30th August 2005

Number of beds: 24 female

DESCRIPTION

St. Bridget's Ward is a locked ward and is located in a block of three wards on the grounds of St. Luke's Hospital. The ward caters for a mix of patients with intellectual disability and those requiring continuing care. There are also occasional direct admissions to the ward, as well as transfers from the admission unit. There are a number of patients waiting for places in an open ward.

REFERRAL

The majority of patients are long-stay patients. Direct admissions to the ward are referred by the consultant psychiatrist on call or by the consultant psychiatrist with responsibility for the ward.

PROCESS OF ADMISSION

All admissions to the ward are assessed by the NCHD and reviewed by the consultant psychiatrist with responsibility for the ward.

CARE PLAN

There is a nursing care plan for each patient. This contains a physical and psychiatric summary, a risk assessment, review records and progress sheets.

NURSING PROCESS

There is a primary nurse system in operation. The Peplau nursing model is in operation on the ward.

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ACCESS TO THERAPY

There is no psychology or occupational therapy input into the ward. Patients may be referred to social workers if necessary. The consultant psychiatrist attends the ward twice a week and on request. The NCHD attends the ward three or four times a week. There are no difficulties accessing medical or surgical services.

ACCESS TO THERAPEUTIC PROGRAMMES

Some patients attend an activity unit on the grounds of the hospital. There are no needs based activities. Ward activities are based on personal hygiene and daily living. There is a snoezelen relaxation room on the ward. There is a people carrier vehicle available to the ward for outings.

SECLUSION

Seclusion is carried out on the ward. There is a seclusion register and 15-minute observation checklist. The NCHD assesses the patient before authorising seclusion documents the decision in the clinical file and the consultant psychiatrist is informed. The seclusion room was bleak. There was a safety mattress and an observation panel in the door and the room was monitored by CCTV. The window pane was loose. One patient was currently sleeping in the seclusion room at night with the door locked at times.

CLINICAL RISK MANAGEMENT

Risk management policies were available on the ward. An individual risk assessment is part of the nursing assessment. It was stated that since some patients with intellectual disability started to attend Cashel day facilities, the number of aggressive outbursts on the ward has decreased.

UNIT MANAGEMENT

There are five nurses on duty during the day and two nursing staff at night. There is one member of

household staff on duty during the day. Meals are at 0845h, 1200h and 1615h, with a snack at 1900h. It was stated that the menu is discussed with the patients and personal choices are catered for.

SERVICE USER INVOLVEMENT

The Irish Advocacy Network number was displayed in the nurses' office. There were information leaflets available for patients. The complaints procedure was displayed for patients.

RECORDS

The clinical notes were up to date and contained regular reviews. There was a treatment plan outlined at regular intervals. The signatures were illegible and no title of personnel recorded. The medication sheets were dated and signed but the signatures were in the main illegible.

ENVIRONMENT

The ward was locked. There was a walled internal courtyard to which the patients have access. There is a designated smoking area provided on the ward and also an outside area with a canopy. The corridors of the ward are narrow with low ceilings and are painted orange. There was a large day room with toilets adjacent to it. There was a large nursing office overlooking the day room. There was a staff room and facilities and nursing office in an annex. The clinical room was well-equipped and there was adequate storage. There was a sitting room which was rather cheerless but has TV and radio. The dining room was large. There was a snoezelen relaxation room. There are seven single bedrooms. There were 7-bed, 5-bed and 4-bed dormitories. Two of the dormitories had no curtains around the beds, which is unacceptable. Banks of wardrobes were at the end of the dormitories. The sluice room was damp and in poor condition and contained two toilets. There were a number of commodes which some patients used at night, even though they were able to use the toilet. A Working Group has been set up to plan an upgrade to the facilities on this ward.

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ST. CLARE'S WARD

Date of inspection: 29th August 2005

Number of beds: 22

DESCRIPTION

St. Clare's is a long-stay elderly care ward. It has twenty-two patients and is located on the ground floor of St. Luke's Hospital. The age range of the patients is from 57 to 98 years old. All of the patients are Voluntary status and there is one patient who is a Ward of Court.

REFERRAL

There is no active admission to the ward. Over the past eighteen months three beds have been taken down. Admissions are discussed with the referring team based on clinical need.

PROCESS OF ADMISSION

The last admission was from the high support hostel in Tipperary town. All decisions to admit are made by a consultant psychiatrist with responsibility for the ward.

CARE PLAN

There are no multidisciplinary care plans in place.

NURSING PROCESS

There are two models of nursing in operation: Peplau model and Orem and King model. There is a primary nurse system in place. Individual risk areas are followed through with specific assessment, e.g. manual handling assessment. There is a high level of physical nursing care required by this group of patients.

ACCESS TO THERAPY

The consultant psychiatrist visits the ward weekly, or as required. An NCHD completes annual physical and

mental state reviews. There is good access to the general hospital located close by for medical and surgical reviews and investigations. There is no access to occupational therapy, social work or clinical psychology. The nursing staff have established good links with professionals based in St. Joseph's Hospital community care department. There are regular referrals and treatment received from speech and language therapy, dieticians, occupational therapy (for seating) and hospice care.

ACCESS TO THERAPEUTIC PROGRAMMES

Two patients attend an area off the ward known as "occupational therapy", but which has no input from an occupational therapist. There is an activation-type programme in place. For the majority of patients who are now ambulant or cognitively impaired there is a very limited programme in place and there is an orientation board. The nursing staff are to be commended for having a chart for each patient indicating personal likes and dislikes. A music appreciation group is planned along with a health promotion project entitled "Go for Life".

SECLUSION

There is no seclusion in place.

CLINICAL RISK MANAGEMENT

There are a number of policies, dated October 2004, which are HSE Area-wide. A new policy on giving medication without consent is under development. There is no policy on restraint. On the day of inspection, one patient was belted into a chair following a fall. All chairs have been provided following assessment by an occupational therapist. A number of patients had tables in front of their chairs, which are moveable. Staff are offered training in mandatory courses. A record of training is kept on the ward. There is an induction programme in place for nursing staff. All incidents are recorded on an incident report form and forwarded to the appropriate offices. A photocopy is held on the ward for reference.

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UNIT MANAGEMENT

One CNM2 and four staff nurses staff the ward in the daytime and there are two staff nurses by night. Staff are centrally rostered but there is consistency in staffing. It is hoped to introduce self-staffing. There are two household staff per day. All staff wear a uniform. The ward is open and there is no CCTV in operation. Visiting times are open. Meals are at set times and a weekly menu is on display. Maintenance is provided by central maintenance but this process can be slow. In a recent audit, there are currently 16 patients who could be transferred to nursing homes or similar accommodation.

SERVICE USER INVOLVEMENT

The Irish Advocacy Network visit on a six-weekly basis. Oral information is provided to patients who make enquiries regarding their medication and treatment.

RECORDS

The nursing and medical charts are separate. The records reviewed showed evidence of annual physical and mental state reviews. The nursing care plans were reviewed regularly based on clinical need. The card index system was in order and medication lists were rewritten regularly. Nursing staff hold a signature bank on site. There was evidence of entries from a speech and language therapist and other disciplines as appropriate. There are no written guidelines on documentation, which results in inconsistent standards. There is a bathing record in place. Financial records of patient accounts were in order.

ENVIRONMENT

The ward area was generally in a poor state of repair. It was an old building that was not suitable for its intended purpose. The layout of the ward with dormitory-style bed areas mixed with day areas was not supportive of privacy and dignity. There were 13 patients in one bed area. The bedroom was in a poor state of repair and the floor was uneven. There were four exit points but only one was open. The other

exits were not suitable. There was no access to an external garden space. Of particular note is that there was one Parker bath for 22 patients. The shower was unsuitable for elderly patients and not in use. There were plans to reconfigure the ward. This would result in eight additional single rooms and a relaxation room. There are currently two single rooms.

ST. JOHN'S WARD

Date of inspection: 30th August 2005

Number of beds: 23 male

DESCRIPTION

St. John's ward is one of three locked wards in a single storey block on the grounds of St. Luke's hospital. The ward provides a mix of continuing care, acute care and care to patients with intellectual disabilities. There were 19 patients on the day of inspection, ranging in age from 25 to 68 years. There were three patients with Temporary status, three with Person of Unsound Mind (PUM) status and the remainder with Voluntary status. While there is one consultant psychiatrist who has clinical responsibility for the ward, there are four teams with admitting rights.

REFERRAL

Referrals to the ward come from a variety of sources including the acute ward and long-stay wards in the hospital, An Garda Síochána, GPs and outpatient clinics. Not all patients have had a full mental health assessment prior to admission. Since the previous inspection, there had been 50 admissions to this ward including 18 transfers from the acute ward and 10 first admissions.

PROCESS OF ADMISSION

There is no admission policy specific to this ward. A consultant psychiatrist makes the decision to admit. A full psychiatric examination and physical assessment is carried out by the NCHD on the day of admission. The NCHD contacts the GP if the patient is admitted on a Temporary form or for further

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information. Nursing staff introduce the patient to the ward and explain the initial treatment plan. The patient is reviewed by the consultant psychiatrist within 24 hours. The patient is nursed in his night clothes if it is felt that there is a risk of absconding. A primary nurse is allocated to the patient.

CARE PLAN

There is no multidisciplinary care planning system in place. The primary nurse undertakes an assessment, which includes an assessment of risk of violence, and a life skills profile. Identified needs and other relevant issues are discussed at the nursing handover meetings. The frequency at which the care plan is reviewed depends on the likely duration of the patient's stay on the ward. Discharge planning takes place for those who are admitted as acutely unwell. Pre-discharge planning meetings are occasionally held.

NURSING PROCESS

The Orem Peplau model of nursing is used. As this does not contain a formal risk assessment, a separate assessment of risk of violence is used. There is a standard level of observation on the ward but special nursing is prescribed on occasion. The nursing staff on this ward are all male. They do not wear uniforms but all wear identification badges.

ACCESS TO THERAPY

There is no specific rehabilitation team in this catchment. There is no access to an occupational therapist or psychologist but referrals can be made to a social worker. The consultant psychiatrist visits the ward twice weekly and when requested and reviews the long-stay patients on a yearly basis. If required, a doctor from South Tipperary General Hospital will visit the ward. Otherwise staff will accompany a patient to South Tipperary General Hospital for medical consultations, or to Our Lady's Hospital, Cashel for surgical consultations.

ACCESS TO THERAPEUTIC PROGRAMMES

There is little by way of therapeutic activity available on the ward. Some social skills training takes place and patients are taken out for walks. Two patients with intellectual disabilities attend a training centre on the grounds of the hospital, which is run by the Brothers of Charity. One patient attends a training/employment centre in the town. Four patients attend an industrial therapy workshop in the hospital for which they receive some payment.

SECLUSION

There is a seclusion room on the ward and there have been 105 episodes of seclusion involving 23 patients since the last inspection. The seclusion room is unsuitable for its purpose and is in poor repair. It is poorly ventilated and does not have easy access to a toilet. CCTV is used but there is no communication for the patient and there is no observation panel in the door. There is a seclusion policy, a register and an observation checklist. Refractory clothing is not used but patients are put into seclusion in the pyjamas.

CLINICAL RISK MANAGEMENT

There is a generic policy on clinical risk management. There are three pinpoint alarms available for staff on duty. There are policies on alcohol and illegal drugs, patients going missing, the management of violent episodes, and searching patients' belongings. A policy on giving medication without consent was being drafted at the time of inspection. There is a policy on physical restraint and incidents are recorded in the patients' files. Staff have received training in control and restraint, de-escalation, cardio-pulmonary resuscitation, and lifting and handling. Formal risk management assessments are documented in some of the patients' files. There is a system of reporting and auditing serious incidents.

UNIT MANAGEMENT

There are no temporary transfers to other units. There is a locked door policy but 17 of the 19 patients were allowed off the ward unaccompanied. CCTV is used in the seclusion room and in four of

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the single rooms. There are five male nursing staff in the daytime and two at night and one household staff in the daytime. There is central rostering on this ward. There is an induction policy for new staff. Dress code is smart clothing. There is no ward clerk. Phlebotomy services are provided by some of the staff nurses. There is no waiting list. According to staff, almost all patients are awaiting appropriate discharge and the majority of patients would be suitable for high support hostels. Visiting times are flexible and there is a visitors' room. Meal times are 0830h, 1200h and 1615h. Snacks are available during the day but most of the patients go to the shop.

SERVICE USER INVOLVEMENT

There are notices on patients' rights, the complaints policy and the availability of an advocate. Information on treatment and therapy is given verbally and there are videos available on some types of treatment. There are no community meetings or formal means of seeking the opinions of patients or families on the service.

RECORDS

The medical files were legible and tidy but need to be better organised. Entries did not have full names and titles. All files contained treatment plans and there were regular reviews by the consultant psychiatrist. All entries and progress reports were signed and dated but there were no entries from occupational therapists, social workers or psychologists. The nursing notes were in good order but not all entries had the titles of personnel. A signature bank is available for nursing staff. Medication records were in good order.

ENVIRONMENT

St. John's ward is a locked ward, comprised of accommodation in single rooms and dormitories, toilets, bathrooms, a large day room, a small nursing office and an enclosed courtyard. There was a shortage of room for interviewing patients and a computer which had been allocated to the ward had

yet to be installed due to lack of space. A sanitiser was recently installed but staff had not been trained to use it. The ward was very badly maintained and urgently required a maintenance plan to be put in place. Window catches throughout the ward were broken. Curtains had not been replaced in the day room. There was no walk-in accessible shower on the ward, or assisted baths. Curtains needed replacing in a TV room where patients had to jam cushions into window spaces in order to prevent the light from the TV from keeping them awake in their adjoining bedroom. The ward needed painting. There was evidence that staff had alerted management and maintenance to the problems in the ward but no evidence that remedial work had been carried out.

ST. KEVIN'S WARD

Date of inspection: 30th August 2005

Number of beds: 24

DESCRIPTION

St. Kevin's ward is a 24-bed male locked ward. All patients are Voluntary status. The ward is under the clinical direction of a consultant psychiatrist.

REFERRAL AND PROCESS OF ADMISSION

There are no active admissions on the ward.

CARE PLAN

There are no multidisciplinary team care plans in place.

NURSING PROCESS

The nursing process is recorded using the Peplau and Orem models of nursing. There is a primary nurse system in place.

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ACCESS TO THERAPY

The nursing team and the consultant psychiatrist provide therapy. The consultant psychiatrist visits weekly and as required, and annual physical and mental state examinations are completed. The patients have access to the full range of general medical services in the general hospital.

ACCESS TO THERAPEUTIC PROGRAMMES

There is no programme on the ward. Six patients with intellectual disability have been assessed and are due to move to purpose-built accommodation. In preparation, they attend the unit on a day basis following on agreed rota for attendance. A number of other patients on the ward access a general programme of activation. This is delivered in the main hospital building. The ward has access to a shared minibus which is used for planned outings.

SECLUSION

There is no defined seclusion room. One patient has been secluded in his own bedroom. The seclusion register was in order. A number of bedrooms are locked nightly from 2030h until 0800h. Patients have no dedicated toilet facilities.

CLINICAL RISK MANAGEMENT

There are HSE Area-wide policies in place. All staff carry alarms with an internal response. Staff are offered training in mandatory courses on a rota basis. It was reported that attendance records are held centrally. All incidents are recorded on the incident report forms.

UNIT MANAGEMENT

This is a locked ward. A number of patients have individual ground leave. The nursing staff are rostered centrally and this is currently under review. Nursing staff have a dress code. Visiting times are flexible. Meal times are fixed with meals coming from a central kitchen and a number of patients require

feeding. For those attending a day service in Cashel, their dinners are held from lunchtime and reheated in the evening. All residents are in receipt of a letter detailing their financial position regarding payments. The financial process has an annual financial audit.

RECORDS

There are two separate charts, nursing and medical. The medical notes have been organised to reflect the current two years of treatment. The chart is neat and manageable. Old medical notes are filed in the ward. The charts reviewed were in order, had evidence of frequent reviews, and include annual physical and mental state examinations. The nursing notes reviewed contained a care plan and notes were recorded weekly or as needed by the primary nurse. There was a signature bank for nursing staff on site. The medication card index had been rewritten recently and was in order.

ENVIRONMENT

The environment was poorly designed and did not reflect the needs of the patient groups. The ward had five single rooms, one double room and three 6-bed rooms. There was one bathroom with a Parker bath and assisted shower. There were separate toilet areas. As many of the bedrooms were locked at night patients did not have access to in-room toilets. The ward activity was centred in a large day area with a nursing office. There was access to an external courtyard area and smoking shelter. The environment was bleak. Provision had been made for a visitors' room and snoezelen room. Meals were eaten in a dining area that was shared with the other two wards, separated by partitions.

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ST. MARY'S WARD*Date of inspection:* 29th August 2005*Number of beds:* 23 integrated**DESCRIPTION**

St. Mary's ward is a stand-alone single storey unit in the grounds of St. Luke's Psychiatric Hospital. It is under the care of the team for Psychiatry of Later Life (POLL). Included in the 23 beds are two respite beds. Fifteen patients require full nursing care. There is one patient detained on Temporary status and one patient detained as a Person of Unsound Mind (PUM). There are three patients with intellectual disability on the ward.

REFERRAL

All referrals to the ward come through the POLL consultant. There are two community mental health nurses who also assess referrals to the service.

PROCESS OF ADMISSION TO THE UNIT

All admissions to the ward are assessed by the consultant for POLL.

CARE PLAN

There is a nursing care plan used on the ward. A weekly team meeting in the day hospital is attended by staff from St. Mary's ward.

NURSING PROCESS

The model of nursing used on the ward is based on the Orem and Peplau models. Efforts are being made to introduce a primary nurse system. There are five nursing staff on duty during the day and two nursing staff on duty at night. It was stated by staff on the ward that it is usual to have only four staff on during the day due to staff shortages. Other sources of information stated that this happened only occasionally due to the non-availability of replacement staff. There are two household staff on duty.

ACCESS TO THERAPY

There is no psychological or social work input to the ward. There is an occupational therapist on the POLL team who has input to the ward one day a week.

ACCESS TO THERAPEUTIC PROGRAMMES

The occupational therapist provides group and individual therapy one day a week on the ward. Each patient referred to the occupational therapist has a needs assessment. Group activities include reminiscence therapy, reality orientation and gardening.

CLINICAL RISK MANAGEMENT

A number of patients were in specialised chairs which have straps for restraint. There were policies on risk management available on the ward. No seclusion was used on the ward. An individual risk assessment is carried out on each patient.

UNIT MANAGEMENT

Bedtimes are staggered with the first two or three patients going to bed at 1630h. Meal times are at 0900h, 1200h, 1615h, and there is a snack at 1830h. Visiting time is open. Respite care is usually for two weeks at a time but can be flexible.

SERVICE USER INVOLVEMENT

There was a complaints policy displayed on the ward. The Irish Advocacy Network number was displayed.

RECORDS

The clinical files were neat and tidy. There were regular entries by the consultant and NCHD. The signatures were, in the main part, illegible, with no title of personnel recorded. The medication sheets also have illegible signatures. The card index system used had no separate sections for PRN or depot medication, resulting in the card index being difficult to follow. The nursing files were clear and legible.

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ENVIRONMENT

The unit is a long ward which is functionally divided into two areas. Maintenance is required in some areas and toilets and showers require tiling. There was a large pleasantly decorated lounge area with a number of specialised chairs. There were five single rooms. The male dormitory was large and bare with a bank of wardrobes at the end of the room. The dining room was small. The nursing office was small and cramped. This overlooked the female ward. There was no such observation of the male ward. Another nurses' office is currently being refurbished.

ST. PAUL'S WARD

Date of inspection: 30th August 2005

Number of beds: 23 male

DESCRIPTION

St. Paul's ward is a single-storey locked ward on the grounds of St. Luke's Hospital. The function of the ward is described as elderly care and medical care. There were 22 patients on the ward on the day of inspection and one was in the general hospital. The patients ranged in age from 47 to 86 years. Eleven of the patients were under 65 years of age. All the patients were of Voluntary status with the exception of one who was a Ward of Court. One consultant psychiatrist had clinical responsibility for the ward. There is no input on this ward from the Psychiatry of Later Life (POLL) team.

REFERRAL

Referrals to the ward come by way of transfers from other units within the mental health service. The consultant psychiatrist discusses potential referrals with the ward manager.

PROCESS OF ADMISSION

There is an admission policy. The consultant psychiatrist and the ward manager make the decision to admit. The person newly admitted is usually accompanied by a nurse transfer form. A nursing

assessment has already been completed elsewhere in the service and the care plan is continued by the staff on this ward. A full psychiatric examination and physical assessment is carried out by the NCHD on the day of admission. Nursing staff introduce the patient to the ward and explain the initial treatment plan. The patient is reviewed by the consultant psychiatrist within a week. The patient is allocated a primary nurse, who is responsible for the care plan, reviews and all aspects of care of the patient on the ward.

CARE PLAN

There is no multidisciplinary care planning system in place. The primary nurse undertakes an assessment of needs according to which goals and objectives are formulated. Entries are made in the patients' notes daily and weekly.

NURSING PROCESS

The Orem and Peplau model of nursing is used in this service. This does not contain a formal risk assessment. There is a standard level of observation on the ward but members of the day hospice team have provided intensive nursing when there have been patients who have been terminally ill. The female nursing staff wear uniforms. All wear identification badges.

ACCESS TO THERAPY

There is a specific team for POLL but they do not have input on this ward. There is no access to an occupational therapist, psychologist or social worker. The consultant psychiatrist visits the ward weekly and when requested and reviews the long-stay patients on a yearly basis. If required, a doctor from South Tipperary General Hospital will visit the ward. Otherwise staff will accompany a patient to South Tipperary General Hospital for medical consultations or to Our Lady's Hospital, Cashel for surgical consultations. A chiropodist visits the ward every three weeks but there is no access to a physiotherapist.

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ACCESS TO THERAPEUTIC PROGRAMMES

There is little by way of therapeutic activity available on the ward. Other activities include household tasks and walking. Bingo takes place and there are occasional outings when a minibus is available.

SECLUSION

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

CLINICAL RISK MANAGEMENT

There is a generic policy on clinical risk management. There are no alarms available for staff on duty. There are policies on patients going missing, the management of violent episodes, and on giving medication without consent. Cot sides are used for safety reasons at the discretion of nursing staff but there is no formal policy on this and the consultant psychiatrist does not prescribe it. Staff have received training in control and restraint, de-escalation, cardio-pulmonary resuscitation, and lifting and handling. There is a system of reporting and auditing serious incidents.

UNIT MANAGEMENT

There are temporary transfers to St. John's Ward. One person recently transferred could not return as his bed had been filled in the interim. There is a locked door policy for safety reasons. Four of the patients are allowed leave the ward unaccompanied but many of the patients do not leave the ward at all. CCTV is not used on this ward. There are five nursing staff in the daytime and two at night and two household staff in the daytime. There is central rostering on this ward. There is an induction policy for new staff. Female nursing staff wear uniforms and dress code for male nurses is smart clothing. There is no ward clerk. Patients' money is dealt with by general office staff and a statement of patients' finances is sent to the ward on a periodic basis. Phlebotomy services are provided by some of the staff nurses. There is a waiting list with one person on that list. Visiting times are flexible and there is a visitor's room. Meal times have to be staggered due to the spoon feeding

of some patients. Snacks and drinks are available during the day.

SERVICE USER INVOLVEMENT

There are notices on patients' rights and the complaints policy. Information on treatment and therapy is given verbally. There are no community meetings or formal means of seeking the opinions of patients or families on the service.

RECORDS

The medical files were legible and tidy. Entries did not have full names and titles. All files contained treatment plans and there were regular reviews by the consultant psychiatrist. All entries and progress reports were signed and dated but there were no entries from occupational therapists, social workers or psychologists. The nursing notes were in good order but not all entries had the titles of personnel. A signature bank is available for nursing staff. Medication records were generally in good order but discontinuation of medication was not always signed and a prescription sheet for depot medication had not been regularly updated.

ENVIRONMENT

St. Paul's Ward is a locked ward, comprised of accommodation in single rooms and two large dormitories. There were sufficient toilets and bathrooms, a day room, a small nursing office. There was a shortage of room for interviewing patients and the nursing office was not private. The ward was very badly maintained and urgently required a maintenance plan to be put in place. The ward needed painting. Ceramic tiles were loose and dangerous in the toilet area. One side of a large dormitory area had no electrical sockets and patients had to be moved on their beds in order for certain electrical equipment to be used. The ECG machine needed servicing as it was not fully functioning. Corridor skylights were leaking and about 20 of the window panels were badly discoloured and needed replacing. The kitchen had a leaking draining board. A sink was required in one of the dormitory areas. There was no garden attached to the ward.

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ST. TERESA'S WARD

Date of inspection: 29th August 2005

Number of beds: 18 integrated

DESCRIPTION

The patients in St. Teresa's Ward had been moved a few days prior to the inspection from St. Catherine's Ward, which had been deemed unsuitable for patients. St. Teresa's Ward is an open ward which had been extensively refurbished and decorated. The ward catered for patients needing rehabilitation, those with intellectual disability and patients requiring continuing care. The age range was between 24 and 67 years. Approximately eight patients are being prepared to move to a new 24-hour staffed hostel in Cashel and two patients were awaiting transfer to the Brother's of Charity intellectual disability services.

REFERRAL

Patients are referred from other wards in the hospital and from the admission unit. All referrals are made to the consultant psychiatrist with responsibility for the ward. There are no admissions of patients under 16 years of age. All referrals are assessed by the nursing staff in St. Teresa's Ward prior to acceptance to the ward.

PROCESS OF ADMISSION

Patients' mental and physical status are assessed by the medical staff and an initial treatment plan is developed. Communication with the patient's family is informal. There are occasional direct admissions to the ward for respite care.

CARE PLAN

A number of patients have undergone assessment in life skills and coping skills as part of the preparation for relocation to the new hostel in Cashel. It is planned that all patients would be assessed over the next few months.

NURSING PROCESS

The care plan is nursed based, with regular reviews. There is no primary nurse system at present but patients are divided into groups for the purposes of nursing care. Allocation to each group is random and not based on functioning or need. It was reported that staff nurses are frequently taken from the ward to cover for shortages in other parts of the hospital.

ACCESS TO THERAPY

There is no psychology or occupational input to the ward. There is access to a social worker on request. The consultant psychiatrist attends the ward weekly and the NCHD attends daily. There is no difficulty in access to medical and surgical services.

ACCESS TO THERAPEUTIC PROGRAMMES

There are some irregular ward-based groups, such as relaxation. There is also a cookery programme. There are occasional outings and shopping trips. Some patients attend a nurse-run activity unit on the grounds of the hospital. The activities are not based on individual needs-based programmes.

SECLUSION

There is no seclusion on the ward.

CLINICAL RISK MANAGEMENT

Policies on management of violence, searching patients' person and belongings and patients missing from the ward were all available. There is an ongoing training programme in the hospital, including training in cardio-pulmonary resuscitation, breakaway techniques and control and restraint techniques. There is an individual clinical risk assessment as part of the care plan. Serious incidents are recorded and are sent to the regional Clinical Risk Manager. An audit of injuries has recently taken place. All serious incidents are discussed with ward staff and nurse managers.

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UNIT MANAGEMENT

Patients are admitted to the ward from the admission very rarely if there are bed shortages. Patients are allowed off the ward whenever they wish and the door is open until 2000h. CCTV is used on the corridors of the ward. There are discussions currently ongoing about self-rostering in each unit. There are a number of patients waiting for discharge to 24-hour supervised accommodation. Approximately four patients could be discharged to lower supervision if a rehabilitation team were in place. Visiting times are open. Meal times are at 0830h, 1200h, and 1630h.

SERVICE USER INVOLVEMENT

Notices about patients' rights and the complaints policy were displayed. An information pamphlet was available. The Irish Advocacy Network contact number was displayed. There is a daily meeting between staff and patients.

RECORDS

New medical files are currently being prepared to replace the existing ones which were untidy. The signatures of the personnel making entries were illegible and no titles were used. There was a treatment plan after each entry. The consultant reviewed patients every six months and physical examinations occur every year. These are recorded on an excellent form which is filed in the clinical file. Medication sheets contained illegible signatures and generic names of medication were not used.

ENVIRONMENT

The ward consisted of two areas that were separated by a courtyard. The décor was excellent and there were new furnishings throughout. There was an activity room and two sitting rooms that were comfortable. There was a nurse manager's office and staff room. The courtyard was very pleasant and had a covered smoking area. The kitchen and dining room were nicely decorated. A training kitchen and relaxation room were still being renovated. Showers and toilets were satisfactory. Male patients had single rooms with their own keys. Female patients were in

double or triple rooms. Keys to individual wardrobes were in the process of being ordered.

SECOND INSPECTION: ST. LUKE'S HOSPITAL, CLONMEL

St. Luke's Hospital, Clonmel was inspected on August 30th 2005. Following inspection the Inspectorate had a number of concerns about the care and treatment of some patients in St. Luke's Hospital. These were as follows:

1. The locking of doors of bedrooms at night in St. Kevin's Ward.
2. The practice of directly admitting patients to long-stay wards.
3. The inappropriate mix of patient groups on St. John's Ward.
4. The unacceptable physical environment.

The senior management team was notified in writing of these concerns and asked to address these issues. They were also informed that an unscheduled second inspection would take place within three months to ensure that these issues were addressed. The second inspection of St. Luke's Hospital was an unannounced visit to the hospital to inspect in detail St. Kevin's Ward, St. John's Ward, St. Bridget's Ward and to review the environment of the hospital.

At the time of the second inspection, there continued to be a mix of patients with intellectual disability and mental illness throughout the wards of the hospital; there had been no change since the previous inspection. The practice of locking patients into their bedrooms at night was continuing at the time of the second inspection. There was one patient in continuous seclusion whose right to privacy and dignity had been neglected. It was evident from clinical files that seclusion was sometimes used because of staff shortages.

The environment in St. John's Ward, St. Kevin's Ward and St. Bridget's ward remained unacceptable. The corridors and bedrooms in St. John's ward had been repainted and a shower installed. There had been some structural improvements in St. Paul's Ward. Apart from this there had been no discernible

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improvements in the patients' living conditions. There continued to be admissions to St. John's Ward, St. Kevin's Ward and St. Bridget's Ward. The main reasons given for admissions to long-stay wards were bed shortages and disturbed behaviour.

Following this inspection the senior management team in St. Luke's Hospital reported that the practise of locking patients in their rooms at night had ceased. The condition of the patient in seclusion had improved. There were plans to move all patients with intellectual disability to one site within the hospital as an interim measure. There is currently an ongoing audit of the practice of admitting patients to long-stay wards. A five-year plan was in draft form.

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

The Mental Health Commission requested a report on the draft five-year plan for the service in May 2006. It also requested a report of the audit on the admissions to long-stay wards in June 2006.

Some of the residents attend a training workshop in the town of Clonmel. Others attend an activation unit on the grounds of the residence. There is an active programme to move residents to lower levels of supervision where possible.

The residence is a single-storey building, pleasantly decorated and with a homely atmosphere. There are four single rooms and three double rooms. There is a sitting room, dining room and kitchen and a laundry room. The residence is open throughout the day and residents are free to come and go. The residents do the shopping for the unit and decide on menus. There are informal unit meetings between the residents and the staff.

This current service could provide a basis for establishing a specialist rehabilitation service which would include the 24-hour supervised residences and result in the scaling down and eventual closure of St. Luke's Hospital.

EDEL QUIN HOUSE

Date of inspection: 31st August 2005

Number of beds: 10 male

Edel Quin House is a medium support residence in the grounds of St. Luke's Residence. There are six long-term residents and four rehabilitation beds. The staff are also responsible for four other residences on the grounds of the hospital (13 residents) and six group homes (23 residents). The service is staffed by five nursing staff, one CNM2, one CNM1 and 2.44 whole time equivalent support staff providing catering and housekeeping services. There is no supervision at night. The long-term residents are referred from the long-stay wards in St. Luke's Hospital and from the admission unit. The rehabilitation residents are referred from the community and from the admission ward. The length of stay for rehabilitation residents is one to three months, although this is flexible. All referrals are assessed by the staff from Edel Quin House using an assessment questionnaire. The decision to admit a resident is made at the fortnightly team meeting. There is no multidisciplinary rehabilitation team with responsibility for this service. Each resident has an individual care plan.

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SOUTH TIPPERARY**MOUNT SION, TIPPERARY TOWN***Date of inspection: 31st August 2005**Number of beds: 10 male, 10 female***DESCRIPTION**

Mount Sion is a large residence with 24-hour nursing staff supervision on the outskirts of Tipperary town. It opened in 1997 but was built in 1930 as a residence for Christian Brothers. Its ethos is mainly continuing care, although there is an emphasis on promoting independence and community integration. The age range is from 40 to 65 years. There is one respite bed.

REFERRAL

Residents are referred by their consultant psychiatrist. The majority of residents have spent extended periods of time in psychiatric hospital prior to moving to the residence and a number of residents have been living in the residence since it opened. There is a specific referral form that is completed by the referring team.

PROCESS OF ADMISSION

Following referral, all future residents are assessed by the residence nursing staff. Following admission to the residence, they are assessed by the consultant psychiatrist.

CARE PLAN

The care plan is developed following the initial assessment. The care plan is nurse led and is based on the Peplau and Orem nursing models. The care plan is regularly reviewed.

REHABILITATION TEAM

There is no rehabilitation team. Care is provided by the nursing staff and medical staff. There are regular

meetings in the residence between the medical and nursing staff. Residents attend outpatient clinics for review. There is no input from social workers, occupational therapists or psychologists. The residents attend GPs of their choice in the town.

INVOLVEMENT IN REHABILITATION PROGRAMMES

The nursing staff provide programmes for residents in the residence. These include life skills, relaxation and community awareness. There are sessions provided in the local day centre for residents and one resident attends a training centre. Holidays and outings occur on a regular basis.

UNIT MANAGEMENT

The residence provides one respite bed. The residence is not used for any other purpose and there are no short-term transfers or crisis admissions to the residence. All meals are cooked in the residence. There are two or three nursing staff on duty in the daytime and one nursing staff on duty at night. There is one household staff during the day and one at night. The unit is mainly self-staffing.

HOUSE RULES

House rules are flexible and residents are involved in their design. Residents have keys to their own bedrooms and their own safe in the bedrooms. Residents are free to come and go during the day and visiting time is open. The kitchen is open as are all the areas in the residence. The menus are planned by the residents who also help with the shopping. The residents are responsible for their own rooms, clothing and personal laundry. Residents manage their own finances. Each has a bank book or post office book and also has an individual personal finance file within the residence. Rent is paid by cash or by direct debit, according to the residents' preference. All personal items and clothing are bought by the residents themselves. The town is within walking distance and the residents are free to go into town when they wish. They use all the community facilities and it was reported that the residence is viewed as part of the community. A

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recent survey was carried out within the community which showed that there was almost full acceptance of the residence as part of the community. A group of staff, residents and local people have formed a fundraising and support group.

SERVICE USER INVOLVEMENT

There is information about the service available to residents. There is a displayed complaints procedure. There are regular residence meetings with the residents about household management and to obtain the residents opinions. The Irish Advocacy Network contact number is displayed. All residents spoken to stated that they were happy to be in the residence. They particularly talked about their independence, freedom to come and go, the choice of food and the attentiveness of staff.

RECORDS

All records are legible, up to date and neat. Medication is dispensed using blister packs.

ENVIRONMENT

The residence is a very large rectangular building set back from the road in extensive grounds. There is a large entrance hall and wide corridors. There are a number of sitting rooms which are nicely decorated and have comfortable furnishings and radio, music centres and TVs. The kitchen is adequate and the dining room large. There is a laundry room and other utility areas. Upstairs there is a long corridor of double bedrooms. Each bedroom has been imaginatively divided using wardrobes to provide some privacy. Each bedroom is individually decorated and personal items are in abundance. The toilets and showers were clean and adequate. There were some maintenance issues, such as tiling and new flooring being required. The nurses' office and clinical room were well equipped. There is no smoking allowed in the residence.

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ST. ANNE'S WARD

Date of inspection: 13th September 2005

Number of beds: 11 male

DESCRIPTION:

St. Anne's Ward is an open ward located in St. Dymphna's Hospital. The function of the ward is to provide continuing care of elderly patients. There are three respite beds. There were three patients who were Wards of Court, all other patients in the ward are of Voluntary status. The age range of the patients is from 52 to 86 years. All patients are mobile.

REFERRAL AND PROCESS OF ADMISSION

There are two consultant psychiatrists with responsibility for patients in this ward. There are very few admissions to this ward, although there are transfers from other wards. Respite admissions come from the community. Length of time of respite is flexible. Patients requiring respite are referred by the community mental health nurse and consultant psychiatrist.

CARE PLAN

There are no multidisciplinary care plans. There are no regular team meetings on the ward. There are nursing care plans.

NURSING PROCESS

The nursing model used on the ward is the Orem Peplau model. Staff felt that this was appropriate to the patient group on the ward. There is no key worker or primary nurse system but there is a team nursing system in place. There are three nursing staff on duty during the day and one staff nurse at night.

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ACCESS TO THERAPY

There is no occupational therapy, social worker or psychology input into the ward but patients may be referred if necessary. The consultant psychiatrist attends the ward on request.

ACCESS TO THERAPEUTIC PROGRAMME

There are no therapeutic programmes on the ward. Patients have access to the Dove Centre, which provides activation and social activities for elderly patients. Patients watch TV and listen to music. There are no organised activities on the ward. One patient occasionally attends the activation centre.

CLINICAL RISK MANAGEMENT

There is no seclusion carried out on the ward. There are policies on patients missing from the ward, the management of violent episodes, and on searching patients. There is a pinpoint alarm system in operation. One patient was restrained in a chair with a strap for safety reasons but there was no restraint policy available. Nursing staff are trained in control and restraint and breakaway techniques, and cardio-pulmonary resuscitation is available if staff wish to avail of training. Serious incidents are reported and followed up by a risk assessor. There is feedback to the staff on the ward.

UNIT MANAGEMENT

There are transfers to the ward due to bed shortages. Patients may be transferred to the other elderly care ward according to physical need. The ward is open and patients are allowed to leave the ward if they wish. There is CCTV used on the corridor outside the ward. There are two household staff on duty during the day. There is no waiting list. There are some delays in obtaining non-urgent maintenance and the ward is currently ready to be painted. Visiting times are open. Meal times are at 0900h, 1300h and 1730h, with snacks in between meals. Bedtimes are by choice. There is a consultant psychiatrist on call at all times. NCHD availability is from 0900h to 1700h from Monday to Friday. Outside these hours the local primary care service CAREDOC provides an on-call service.

SERVICE USER INVOLVEMENT

Information leaflets are available on request for patients and relatives. There is a notice board for patients outlining ward activities and other information. There is a complaints policy available. There was a suggestion box on the ward.

RECORDS

The clinical files were untidy. Progress reports were signed and dated but most of the signatures were illegible and no titles of personnel were used. Some patients had not had six-monthly physical and psychiatric reviews. The nursing files were satisfactory. Medication sheets were in satisfactory condition, signed and dated although many signatures were illegible.

ENVIRONMENT

The ward needed redecorating. There was a large day room which included a dining area. It had a TV. There were no activities available and there were six or seven patients asleep in the day room even though it was 1200h. There was a 9-bed dormitory which was sectioned by glass partitions. Each bed had wardrobes and curtains and some areas had personal possessions. There were two toilets adjoining the dormitory. There was a large room with three beds which had wardrobes and curtains around the beds but was quite bad. There was a smoking room with a TV. There was a bathroom with a Medi-bath on the ward and only one shower. There was a visitors' room which doubled as a quiet room. The ward had no nurses' office and the staff used a corner of the day room as an office, consequently, issues of confidentiality arise.

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ST. MARY'S WARD

Date of inspection: 13th September 2005

Number of beds: 22 integrated

DESCRIPTION:

St. Mary's Ward is located in St. Dymphna's Hospital and is an open ward. The function of the ward is to provide continuing care to elderly patients. There are two respite beds. All patients in the ward are on Voluntary status. The age range of the patients is from 50 to 85 years. Seven patients are under 65 years of age.

REFERRAL AND PROCESS OF ADMISSION

There are two consultant psychiatrists with responsibility for patients in this ward. All referrals come through the consultant psychiatrists and have first been assessed and treated in Department of Psychiatry in St. Luke's Hospital in Kilkenny. Referrals for respite care come from the community mental health service. It was reported that there have been four admissions to the ward and one discharge in the past year.

CARE PLAN

There are no regular team meetings on the ward. There are nursing care plans but no multidisciplinary care plans.

NURSING PROCESS

The nursing model used on the ward is the Orem Peplau model. Staff felt that this was appropriate to the patient group on the ward. There is no key worker or primary nurse system due to the lack of continuity of staff. There is a team nursing system in place. There are usually five nursing staff on duty during the day and two staff nurses at night. On occasions there are three nursing staff and one student nurse on duty during the day. There is a training system in place for health care assistants.

ACCESS TO THERAPY

There is no occupational therapy or psychology input into the ward. There is social worker input into the ward. The consultant psychiatrist attends the ward on request.

ACCESS TO THERAPEUTIC PROGRAMMES

Some clients attend an activation centre in the hospital and the Dove Centre programme is available. There are no therapeutic programmes on the ward.

CLINICAL RISK MANAGEMENT

There is no seclusion carried out on the ward. There are policies on patients missing from the ward, the management of violent episodes, and on searching patients. One patient is restrained in a chair with a strap for safety reasons. This practice has been discussed with the patients' family. However, there is no restraint policy and the times of restraint are not recorded. Nursing staff are trained in control and restraint and breakaway techniques, but stated that they require refresher courses. Serious incidents are reported and followed up by a risk assessor, with feedback to the staff on the ward.

UNIT MANAGEMENT

There are no short-term transfers to the ward due to bed shortages. There is no waiting list. The ward is open and patients are allowed to leave the ward if they are physically able to do so. There is no CCTV used on the ward. There are two household staff on duty during the day. There are some delays in obtaining non-urgent maintenance. Visiting times are open. Meal times are at 0900h, 1300h, and 1730h with snacks in between meals. Bedtimes are by choice and patients may rest in bed during the day if they wish. There is a consultant psychiatrist on call at all times. NCHD availability is from 0900h to 1700h from Monday to Friday. Outside these hours the local primary care service CAREDOC provides an on-call service.

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SERVICE USER INVOLVEMENT

Information leaflets are available on request. There is no notice board for patients and the complaints procedure and patient's rights are not displayed. There is a complaints policy available. There was a suggestion box on the ward.

RECORDS

The clinical files were tidy. Progress reports were signed and dated. Most of the signatures were illegible and no titles of personnel were used. Some patients had not had six-monthly physical and psychiatric reviews. Medication sheets were signed and dated. However, many signatures were illegible.

ENVIRONMENT

The ward was arranged along two long corridors. There were two nurses' offices. The day room was bright and had a pet bird and fish. There was access to a pleasant garden area with plenty of seating. There was a visitors' room and a multi-purpose room, which was occasionally used by the occupational health department. The dining area was in an alcove. There are plans to reduce the area of the smoking room and extend the dining area, which is currently too small. There were 6-bed, 5-bed, and 4-bed dormitories. All dormitories had wardrobes and curtains around the beds although they were cramped. Each room had a TV and there were plenty of personalised items. There was also a single room. The toilets were modified for disabled patients. There were two bathrooms with specialised baths and one shower. The ward required re-painting and the bathrooms require tiling.

ST. PATRICK'S WARD

Date of inspection: 13th September 2005

Number of beds: 20 male

DESCRIPTION

This is an open ward on the ground floor of St. Dymphna's Hospital. It is a 20-bed, all male, continuing

care and rehabilitation ward. On the day of inspection, there were 18 residents. There was one detained patient and two Wards of Court.

REFERRAL

This is a continuing care and rehabilitation ward. There were rarely direct admissions to this service, patients usually being transferred here from other wards. Acute patients go to the Department of Psychiatry in Kilkenny or to the crisis beds in Greenbanks, Carlow.

PROCESS OF ADMISSION

One patient was transferred in from St. Anne's Ward for the purpose of seclusion. There was one admission from Greenbanks and one patient was transferred from the Department of Psychiatry prior to discharge home. In the past year, a female was admitted to a single room at the end of the ward due to the absence of a similar facility for female patients. Separate arrangements were made for her regarding her bathroom facilities. Two patients have been transferred out to the elderly unit and one patient self-discharged against medical advice. There are no admissions of children under 16 or patients with a moderate intellectual disability, and no admissions for detoxification. Any admission to this ward is generally planned and known to the service in advance. The consultant psychiatrist makes the decision to admit along with the team. An assessment is performed prior to admission and the duty NCHD performs the physical following admission. There is no formal policy on observation levels. Currently two levels of observation are recognised: close observation and general observation. There is a primary care nurse system in place as opposed to a key worker system.

CARE PLAN

Weekly sector meetings are held in the day centre and they are attended by the Assistant Director of Nursing for the area. The patients are discussed at this meeting. There is no ward-based review meeting for patients. The NCHD visits the ward on a once or

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twice weekly basis and reviews patients as required. At the sector meeting there is attendance by the social worker and psychologist but not the occupational therapist although it is planned to recruit an occupational therapist to the service. The nursing officers in charge of the ward do not attend the sector meeting because of shortage of nursing staff. Some patients may never be reviewed at the sector meetings.

NURSING PROCESS

The nursing staff use a nursing model of care based on Peplau and Orem models. They have an adapted care plan which is individualised and is reviewed every two months. It does not contain a formal risk assessment.

ACCESS TO THERAPY

Patients can be referred to see the psychologist or a social worker. There is access also to counsellors if required. The consultant psychiatrist visits the ward once a month and reviews the patients' status at the sector meetings off the ward once a week. Medical and surgical consultations are accessed in St. Luke's Hospital, Kilkenny. Nursing staff stated that they do not have the resources to attend the sector meetings.

ACCESS TO THERAPEUTIC PROGRAMMES

All patients in this ward are encouraged to attend to their own personal hygiene needs and social skills, and these skills and needs are reinforced in the Dolmon Centre where 11 of the patients attend daily from 1000h to 1600h. The Dolmon Centre is on site on the first floor. Strong emphasis is placed here on regular social skills allied to recreational and therapeutic activities. Some patients go to the Dove Centre. Depending on ability some patients may go to Skills Base. In addition they are occupied in areas such as laundry, visits home, knitting work, writing skills and maintaining window boxes. In addition two group programmes are conducted in the ward, one on "Managing Your Own Mental Health" and the other on "Self Esteem and Communication". These are facilitated by the nurse counsellor. In addition, a regular community meeting is held.

SECLUSION

It had been intended, when relocating this ward, that there would be no seclusion. However, it has been used on three occasions involving two patients since the last inspection. Guidelines and procedures were available regarding seclusion. Seclusion facilities have not been updated or provided in line with modern practice because of the expectation that they would not be used, and that the rooms would be used instead for storage. However one of the rooms is available for use. It was clean, there was a mattress on the floor, there was adequate ventilation, it was well lit, there were no curtains on the window, there was access to a toilet and an observation panel on the door. It was quite unsafe, in that the door opened inwards and was not very wide. Refractory clothing is not used and there is no CCTV.

CLINICAL RISK MANAGEMENT

There is no formal policy on clinical risk management and as for the rest of the hospital there was an infection control manual. There were policies on patients absconding, alcohol and illicit drugs, the management of violent episodes and searching patients' belongings. There were no policies on giving medication without consent or rapid tranquillisation. There was no policy regarding the use of physical or mechanical restraint. However, physical restraint is documented in accordance with the approved techniques utilised by nursing staff. Information subsequently received stated that guidelines and procedures are available regarding giving medication and regarding restraint.

Staff are trained in breakaway techniques and some have taken the course in control and restraint. In fact, a CNM2 for the area is an instructor and this is an area for training staff or receiving the preceptorship training. cardio-pulmonary resuscitation training is also available. The clinical placement coordinator is responsible for developing in-service training, which is done on a regular basis on issues such as medication. There is no individual clinical risk assessment documented in patients' charts. Staff use the standardised method of reporting serious clinical incidents and these are relayed to the Risk Care Manager and the Occupational Health and Safety Manager depending on the injury. Serious incidents

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are audited. If there are three incidents there is a full investigation and debriefing is available when required and requested.

UNIT MANAGEMENT

There are no temporary transfers to other wards. Patients may be moved to the other wards on the campus due to increasing infirmity and age; two patients have been moved for this reason during the last year. There is a ward programme available on the ward with the activities already mentioned. This is an open ward so the door is never locked. Some patients are not allowed to leave the ward unescorted but the majority can do so. The ward is not used for any other purposes. There are two nursing staff on in the daytime and one at night. There is central rostering. There are two household staff on all week.

There is an induction package prepared by the clinical placement coordinator with a checklist and this is also used for inducting new staff. There is a dress code involving uniform for the females and smart clothes for the men. All staff wear name badges. There is no ward clerk. Some of the staff are being trained in phlebotomy but currently bloods are taken by either the duty doctor or by the phlebotomist at the day hospital. There is no waiting list. There is no outside line from the ward however there is a speed dial facility on the phone to the Garda Síochána and hospital. Visiting times were flexible and within reason there is free availability of snacks and drinks although some patients are not allowed into the kitchen alone. There is a shop across the road. Meal times are at 0900h, 1300h and 1730h with regular coffee and sandwich breaks.

SERVICE USER INVOLVEMENT

Leaflets are on display in the communal areas of the ward with notice boards. There is a patients' charter prominently displayed and a complaints policy. In addition there are suggestion boxes with suggestion sheets. There are ward community meetings and there is access to advocacy. There are plans to have three notice boards outside the clinical room relating to ward issues, local issues and STEER.

RECORDS

The medical notes were legible and tidy, and the patient name and ID number was on all pages. Entries had the full name but not the title of personnel. Allied health professionals wrote in the charts on separate sheets. There was a nursing care plan. The registrars attended twice a week but did not necessarily make entries in all the patients' charts and there was evidence of discussion by the consultant psychiatrist of the care plan but few entries into the nursing notes. The nursing files were satisfactory in all respects, however the title of the nurse was not always provided. Medication, prescriptions and administration records were satisfactory. The chart of a patient who was secluded was reviewed. Because this seclusion had occurred over a weekend the patient was not reviewed by a consultant psychiatrist or NCHD for over 36 hours.

ENVIRONMENT

St. Patrick's Ward is located on the ground floor and in the right wing of the complex. The nursing station was located in the centre of the ward. To the right of the nursing station along the entrance hall there were four single bedrooms and one double bedroom, a visitors' room, store area and clinical room. The visitors' room had comfortable furnishings. The seclusion room was also off this side of the ward. There was one toilet directly beside the seclusion room that was currently being used predominantly by one male patient in particular. There was one shower area off the seclusion room that was not in use. There was access to the Dolmon Centre upstairs and to an outside door. Across from the nurses' station on the right hand side was the clinical room, which also doubled as an interview room. There were no windows in this room. Bloods were taken in this room, drugs were stored there along with first aid equipment, oxygen and sharps disposal. Clinical case notes were also kept in this room.

Directly opposite the nurses' station, two large 7-bed dormitories could be observed. The curtains around the beds were all on non-collapsible rails. Given that some of the patients admitted here have been quite disturbed, this might need to be reconsidered. Both of these rooms had toilets en-suite with a room on the right having a bath and shower area. The shower

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was unsatisfactory; it was quite small and difficult to clean. There was a Parker bath in the bathroom with a non-functioning jacuzzi feature. The second dormitory had two toilets, two wash-hand basins and counter wipes were used rather than hand dryers for hygiene reasons. In the reception area directly outside the nurses' station the suggestion box was on display along with a public phone, the primary nursing board was displayed along with leaflets.

Food was prepared in the Sacred Heart Hospital, cooked fresh and delivered on trolleys. There was a large dining room which was a pleasant room. It also housed the pool table which was regularly used. Families sometimes chose to see their relatives here rather than in the visitors' room. There was a lounge area which had been sectioned into a non-smoking area and a smoking area at the rear. The non-smoking area was further subdivided into a quiet corner in an area with a TV. There was comfortable seating, books, new furniture, and notice boards. The fans in the smoking area worked very well and there was no evidence of smoking in the non-smoking room and patients were sitting out throughout the area. There was a need for more comfortable chairs. There was also an exercise bike and a stepper exercise machine in this room, which looked out onto the garden. Staff had a toilet room but otherwise no other facilities for their use. There was access to a sitting room and library upstairs. Staff were quite satisfied with the size of the nurses' station and used the dining room also for meetings with students. Patients had their own keys for lockers. There was adequate storage space in the ward.

KELVIN GROVE

Date of inspection: 13th September 2005

Number of beds: 18 places, 7 male, 9 female

DESCRIPTION

This is a locked unit located in a two-storey listed building across the road from the main St. Dymphna's hospital. Only the ground floor area is in use, the upstairs is left vacant. This ward is a long-stay unit for patients with learning disability and psychiatric illness. It is not under the care of any specialist learning disability service or in receipt of specialised input of

any kind. There are plans to sell this house and to relocate to four 5-bed purpose-built units in the grounds of the hospital, with an association with the day unit for patients in the service. However it is envisaged that it would remain under the care of the mental health services. There are also plans to have four respite beds for acute admissions of those with challenging behaviour. Because there have been plans to close this unit for many years it has been let go into a state of disrepair and neglect with little evidence of any ongoing maintenance, with the exception of minor maintenance, or of any active clinical input.

Of the residents currently in Kelvin Grove, eight come from Kildare and eight from the Carlow area. There are currently 16 residents ranging in age from 28 to 65 years.

REFERRAL AND PROCESS OF ADMISSION

There has been one admission from the Department of Psychiatry in Kilkenny in the last year. This patient has since moved to a long-stay ward. The patient was admitted because of acute agitation. There have been no other admissions for a number of years thus there is no agreed policy for process of admission to service. If the unit relocates as is planned there should be a clearly defined policy and procedure regarding admission, both for respite or for long-stay beds. Up to now the decision to admit has been made by the consultant psychiatrist for the area and patients generally have been assessed prior to coming to this unit.

CARE PLAN

There is no evidence of any multidisciplinary care planning. There appears to have been no input from psychologist, social worker or occupational therapy for a considerable period of time due to shortage of staff. The NCHD attends the unit twice a week to attend to the medical needs of the patients. There is little evidence of any direct consultant psychiatrist reviews. The consultant psychiatrist visits on request. There are no meetings on the ward between medical and nursing staff. There was no evidence of any formal psychiatric review of patients. Medical reviews of all patients occur on a six-monthly basis.

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Information received subsequently states that detailed care planning for each patient has been undertaken by the responsible consultant psychiatrist in conjunction with the nurse in charge and that updated care planning is now nurse led.

NURSING PROCESS

The nursing staff working in this unit do not have a professional qualification in intellectual disability. They have however undertaken a programme on care of persons with learning disability which was provided by an external provider.

With regard to the nursing process, the nursing staff have developed their own Kelvin Grove residents assessment and care plan. This incorporates an assessment and care plan for residents with challenging behaviour in Kelvin Grove. It does not contain a risk assessment. This care plan is reviewed on a six-monthly basis. There is no key worker system in operation. Two CNM2s are regularly working in the unit. They operate a primary nurse system and two teams are set up each day to complete the ward routine. There is no formal policy on observation. Female staff wear uniforms and name badges. The male staff wear their own clothes and name badges.

ACCESS TO THERAPY

There is no access to a psychologist, occupational therapist, or social worker, or to counsellors. The consultant psychiatrist reviews and discusses patients with the registrar when required. Review by the consultant of the patients was infrequent. The house officer visits the ward twice a week and for emergencies. There is a difficulty in obtaining laboratory and X-ray results.

ACCESS TO THERAPEUTIC PROGRAMMES

One younger patient attends the Dove Centre but the activities there are intended for patients over the age 65 years. Patients attend hydrotherapy and go on outings with staff. There is a detailed activity timetable which seemed to be adhered to involving use of the multi-sensory room and a jacuzzi, video, music, crafts, game and regular outings. Outside of

these times, residents are encouraged to participate in the daily hygiene programmes, household skills and care of personal affects.

SECLUSION

One room off the male dormitory was used for seclusion in the past. A register of seclusion is kept on the ward. No seclusion had been documented since 2003 when it was used for a patient who has since been moved to another service. There is a seclusion policy available on the ward. The staff have decommissioned the seclusion room by removing any furnishings from the room and leaving the door open and discouraging its use. There is no CCTV in use. The seclusion room appeared to be satisfactory.

It came to the attention of the Inspector that a patient has been regularly placed alone in a locked room (day room) at certain meal times due to staff shortages and this has not been documented in the seclusion register. This has been authorised over the telephone. One patient in fact was secluded earlier this year in the observation room upstairs and it was documented in the nursing notes that the observation room was used. Because it occurred at night it was deemed not to be seclusion.

CLINICAL RISK MANAGEMENT

There was no policy on risk management available on the unit although there was a hostel health and safety statement and infection control manual available. There is a hospital-wide alarm system with receivers and transmitters and this is tested weekly. There is a policy on the use of alcohol and illegal drugs, patients absconding and the management of aggressive incidents. There is no policy on rapid tranquillisation or on giving medication without consent. There was a policy on searching patients' belongings but not on searching their room or bed area. Of concern is that there is no policy available in relation to the use of restraint. The Inspectorate was informed that mechanical or physical restraint was not in use. Buxton chairs are in use for the purposes of prevention of falls or self-injury. However there needs to be a policy regarding documenting its use for these reasons. Serious clinical incidents are investigated and audited in the standard way across

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the HSE Area and data regarding these are sent to the Risk Assessment Officer and debriefing is available following serious incidents.

UNIT MANAGEMENT

There are no temporary transfers or long-term transfers to other units. Most of the patients require an escort or some assistance to leave the ward. One patient regularly goes across to the hospital to visit her friends and another patient is collected to attend the day centre. The remainder remain on the ward. As stated the ward is locked. There is no CCTV in use on the ward. The ward is not used for any other purposes. There are four nursing staff on in the daytime and two at night and this is by central rostering. There are two household staff on in the daytime.

To date, the process for induction of staff has been informal and this needs to be updated. Staff are currently in the process of receiving their preceptorship training. There is a dress code. There is no clerical support or phlebotomist available. The NCHD takes the bloods when required. There is no waiting list for the unit and none of the patients currently are awaiting discharge placement elsewhere. Staff expressed some concerns about the lack of maintenance and felt that the maintenance needs of the unit were of a low priority. For example a door has been requested to block off access to the stairs for the last six months and has not been attended to as yet. There is clear evidence around the ward of poor decor.

The unit does not have an outside telephone line but must use the hospital switchboard. Visiting times are flexible. The patients have regular access to snacks and drinks with staff assistance. Meal times are 0900h, 1300h and 1730h or 1800h. There was little evidence of service user or family or carer involvement. There are no unit community meetings with patients and there is no access to advocacy.

RECORDS

The medical files had the patient name and ID number on all pages. They were legible and tidy, and a signature bank was available. Entries were signed but the title of personnel was not always given.

Entries were clearly signed and dated. There were no progress reports from allied health professionals or evidence of active treatment planning. There was no evidence of consultant review on the charts perused and there were irregular NCHD reviews. Six-monthly physical examinations were done. Nursing staff wrote notes in the nursing files on a regular basis, at least twice a month and often much more frequently. They were legible and tidy. Entries were signed but again the title of personnel was not given. There was a signature bank available. Medications were signed, dated, and legible, and generic names were sometimes used. Discontinuation of medication was signed and dated. Some of these index cards were rewritten on a regular basis whereas others had a box to sign where they had been reviewed. The chart of the person who had been placed in the observation room (secluded) was inspected and there was evidence in the nursing notes that they had been locked into the observation room but this was not clear from the medical notes.

ENVIRONMENT

This is a two-storey building across the road from the main hospital. It is a listed building with a listed conservatory which is not in use. The front door opened to an entrance hall to the left of which was situated the nurses' station or office which doubled up as an interview room for medical staff. Directly off the nurses' office was the multi-sensory room. Throughout the unit as a whole there were many homely touches and attempts to make the unit more pleasant and homelike with murals on the wall, ornaments and toys. Directly in front of the main door was the staircase and to the right there was a recreation and visiting room in which various activities were being conducted. There was a table with some leaflets available on it. Off this room there was a storage area which housed a computer and wheelchairs. Again, on going through the recreation visiting room there was another large day room. This in turn led to a dining area.

There were two dining rooms in this unit, one for patients with more severe disability with plastic all-in-one seating and table units. This room was grim in decor, with a TV in the corner and it was poorly ventilated. This opened back into the entrance hall which extended to the rear and off which there was

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a shared bathroom area. All the bathroom areas were unisex and in this area there were a couple of toilets. A wheelchair-accessible toilet, an ordinary toilet, a urinal and two wash-hand basins, the taps of which were constantly running. There was a fire escape door out of this unit. The doors did not lock and there was little opportunity for privacy. Another bathroom was housed in a second area, which was known as the changing area for patients, where patients were washed in a Parker bath which also had a jacuzzi feature. There was a phone, washing machine and dryer. Staff wash some of the patients' personal belongings or assist the patients to do so. Patients' personal belongings are sometimes washed in the hospital laundry. There were three wash-hand basins. Again none of the doors were lockable. There were no showers on the unit.

Outside there was a secure yard of concrete. The minibus was stored in this area at night which means that no furniture can be left out there overnight. Tea and coffee were being served there during the visit. There was a smoking area off this yard and a basketball hoop and a sand area. There was no grass.

There was an indoor smoking area and in the same room a table was used for the serving area for the dining room. There was a second dining room for patients who had moderate-to-mild learning disability. Six patients sit down at tables. Three are served meals at their own chairs. This room doubled as a lounge area in the evening and there was an absence of enough comfortable seating. There was a TV and a radio here. One of the patients was busy doing pictures.

There was a clinical room at the top of this room which was small and cramped. It contained the medicines trolley, spare medications and injections, sharps disposal and an oxygen cylinder. There was no cardio-pulmonary resuscitation equipment and no couch. Patients were examined in their own beds.

This room led into the male dormitory area which had seven beds; all the beds had lockers and wardrobes. There were some partitions but no curtains around the beds. Off the top of the male dormitory there was a room that used to be used for seclusion. This had shutters and was ventilated and all the furniture had been removed to discourage the use of this room for seclusion or time out. The bedroom dormitory had some toilet facilities off it.

There was a female dormitory with eight beds, one of which was unoccupied. This was a nice and bright room formerly used as a day room. It overlooked an outside area which in the past had been used as a garden for the unit. Consideration should be given to redeveloping this area if the move towards new purpose-built facilities is to be deferred or delayed. Again there were individual lockers and wardrobes. There was a bathroom directly opposite the dormitory with a Parker bath which was only used in emergencies and in fact seldom used and two toilet cubicles. Again the doors could not be closed, in fact one of them was hanging very poorly. There were some wash-hand basins.

There were two single rooms at the top of the ward which were occupied by two patients who were deemed to be rather disturbed. One of these rooms had a bed only and the other had a bed and soft chair. The wardrobes for these patients were kept on the main dormitory area. Throughout the unit there was evidence that staff had made significant attempts to make the environment more home-like. There were no notice boards on display apart from the nursing staff's office. The only area that could be used as a quiet area was the multi-sensory room or the visitor-cum-activity room if it was not otherwise occupied.

DAY HOSPITAL

Date of inspection: 14th September 2005

Number of beds: Not stated

DESCRIPTION OF SERVICE

The Day Hospital at St. Dymphna's Hospital was opened in conjunction with the Department of Psychiatry, Kilkenny and Greenbanks Hostel. Prior to the inspection it had recently moved its facilities and now also encompassed the Day Centre. It operates seven days a week from 0830h to 2000h.

REFERRAL

All patients presenting to the service are seen and assessed at the day hospital. Referrals come from the GPs, the local primary care service CAREDOC,

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Greenbanks Hostel and consultant psychiatrists at the Department of Psychiatry, community nurses and other members of the team. There is a detailed protocol for GP telephone referrals and policies for the management of all categories of referral – routine, emergent, urgent and self-referrals. The local primary care service CAREDOC has been issued with a protocol for out-of-hours psychiatric referrals. Outpatient clinics are held here and a medical report is issued to the GP based on a standard format.

NURSING PROCESS

The total number of staff is three clinical nurse managers, one working 0900h to 1700h and two who work from 0830h to 2000h on three days each, the staff doubling up on Mondays. A review of the statistics for this service show that the attendance has gradually increased from a monthly attendance of 481 in January 2004 to 878 in August 2004.

CARE PLAN

There is no formal multidisciplinary care planning.

ACCESS TO THERAPY

The consultant psychiatrists for each of the two sectors have weekly multidisciplinary team meetings which the psychologist and social worker attend. The occupational therapist has recently left the service but a new one is commencing shortly. There is also one addiction counsellor for the service, the second having left recently. There is psychiatric NCHD cover five days a week with one NCHD in attendance on five days and another on three days.

ACCESS TO THERAPEUTIC PROGRAMMES

Group activities or activation programmes are delivered elsewhere. Patients can be referred to the Dove Centre depending on age, the Dolmon Centre, Skills Base, or for individual counselling or therapy.

CLINICAL RISK MANAGEMENT

The staff interviewed were fully aware of the HSE area-wide policies and procedures and were incorporating these into the service.

SERVICE USER INVOLVEMENT

Staff expressed interest in developing a leaflet and establishing clear protocols for liaising with GPs. in the area.

RECORDS

Service statistics are kept and documentation was up to date. A standardised out-patient report is issued following each attendance. Patient case files were not perused.

ENVIRONMENT

The unit was pleasantly decorated. It consisted of a pleasant entrance area and waiting room, offices and an occupational therapy training kitchen and toilet facilities. There were information leaflets and notice board displayed in the waiting areas. There was a water dispensing machine. There was a suggestion box on display and offices were clearly labelled. There was also a clinical room from which medication was dispensed and many patients attended on a regular basis for this.

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CARLOW/KILKENNY**SACRED HEART RESIDENCE***Date of inspection: 14th September 2005**Number of beds: 8 beds, 4 male, 4 female***DESCRIPTION**

This is an 8-bed bungalow adjoining the hospital in the grounds of Sacred Heart Hospital which opened three years ago for the care of patients with learning disability. The ethos of the residence is to rehabilitate patients to their optimum level of functioning and to maintain functioning by repetition and training. It is a residence with 24-hour nursing staff supervision. All patients in this residence are in the care of the Carlow sector teams. There is a strong emphasis on individuality, independence and normalisation.

REFERRAL AND PROCESS OF ADMISSION

The majority of patients here came from Kelvin Grove. There has been one admission in the last year following the death of one of the residents. This patient was transferred from another residence. There are no crisis admissions to the residence and there is no respite service provided by the residence.

CARE PLAN

There is a comprehensive care plan system in operation which is administered by the nursing staff. The residents have a yearly quality of life assessment and there is also a yearly family satisfaction questionnaire. Residents are assessed by a life skills profile which is the basis for the individual care plan and are reassessed every three months. The residents are involved in their own care plan. There is no multidisciplinary input into the care plan. There were no discharges from the residence over the past year.

NURSING PROCESS

The care plan is administered by the nursing staff. There are two nursing staff on in the daytime with a housekeeper and one by night. There is no housekeeping support at weekends.

REHABILITATION TEAM

There is no multidisciplinary rehabilitation team with responsibility for the residence and there are no team meetings in the residence. Residents attend the outpatients department for review. Each resident has their own GP.

INVOLVEMENT IN REHABILITATION PROGRAMMES

There is no full multidisciplinary rehabilitation team in this service. Three of the patients attend the Dove Centre. Four patients attend the Dolmon Centre and one patient remains in the residence during the day.

UNIT MANAGEMENT

Since the controversy regarding nursing charges, residents did not pay for their upkeep and received disability allowances. They made payments for laundry and Sky TV. The staff did the cooking, washing and ironing and reported that they would like training if required to work in this area. At weekends the nursing staff were required to cook all the meals. All meals were prepared on site. Residents assisted in preparing the tables, clearing the dishes, and in the shopping. The staff appeared enthusiastic, interested and committed. All patients go on holidays for a week every year. There was a strong emphasis on improving the residents' quality of life.

ETHOS

There was an emphasis on care planning and rehabilitation in the residence. All policies and procedures were excellent. Most of the residents were receiving continuing care with little prospect of moving to lesser supervision due to their learning disability.

SERVICE USER INVOLVEMENT

This residence, like the others, is part of the ISO Quality Programme and has a regular review of satisfaction with the service conducted.

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RECORDS

The clinical files were in excellent condition and all residents had been reviewed within the previous few months. Medications are prescribed initially by the psychiatrist and then prescribed by the residents' GP.

ENVIRONMENT

This is a homely, pleasantly decorated bungalow off the Old Dublin Road. On entering the bungalow there was a nursing office on the left hand side and a smoking room on the right hand side. The dining room, directly in front of the entrance hall, was a large, bright room with large windows overlooking the garden and patio area. There was a kitchen off the day room leading into the utility room which opened outside. This was a door out onto the female wing. On the right hand side of the dining room there was a sitting room which was pleasantly furnished, with TV, books, games and videos. There was a staff toilet, a linen room and a storage room for kitchen supplies and cleaning supplies. There were two halls, one with four male bedrooms and the other with four female single bedrooms. These rooms were all pleasantly decorated and were colour coded. There was a single bed, wardrobe, locker and mirror in each. All patients had their own wash bags and dressing gowns. There was a shower room at the end of the male and female wings. All rooms had their own power points. There was a bathroom, toilet, wash hand basin and bath on each side. The residence was not wheelchair accessible. There was an extra toilet in the female side. There was a pleasant outside garden area. The whole area was clean and well maintained, bright and cheerful.

ST. CANICE'S HOSPITAL, KILKENNY

ST. JOSEPH'S WARD

Date of inspection: 14th September

Number of beds: 24 integrated

DESCRIPTION

St. Joseph's Ward is located on the ground floor in the main hospital building in St. Canice's Hospital. The emphasis in the ward is on continuing care of

elderly patients although there are a small number of patients under the age of 65 years on the ward. There was one patient who is on Temporary status and two Wards of Court on the ward at the time of inspection. All patients are under the care of one consultant psychiatrist. It is planned that within the next three months the patients will move to recently refurbished ward on the grounds of the hospital adjoining another elderly care ward. As beds become empty in the new ward they will be filled by patients under the care of the Psychiatry of Later Life (POLL) consultant psychiatrist. There will be five additional beds for those with dementia and challenging behaviour including two respite beds in the ward. There will also be a day hospital for POLL adjoining the new ward.

REFERRAL AND PROCESS OF ADMISSION TO THE WARD

There has been one admission to the ward in the past year. At the time of the inspection there were two people on the waiting list for the ward. There are no beds available at present for a respite service.

CARE PLAN

There is a nursing care plan on the ward and meetings are held between medical and nursing staff every two weeks.

NURSING PROCESS

The model of nursing used on the ward is based on the Orem model. Efforts are being made to introduce a primary nurse system but this has proved difficult due to lack of continuity of nursing staff. There are four nursing staff on duty during the day and two nursing staff on duty at night. However, there are also health care assistants in training in the hospital and sometimes a third year student nurse and one health care assistant replace one of the nursing staff during the day. There are two household staff on duty for part of the day.

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ACCESS TO THERAPY

There is no psychologist or social worker input to the ward although patients may be referred if necessary. An occupational therapist occasionally sees individual patients and offers seating assessments.

ACCESS TO THERAPEUTIC PROGRAMMES

The occupational therapist does not provide therapeutic programmes to the ward. There are no needs-based activities. Activities on the ward consist of watching TV, listening to music, doing jigsaws and occasionally playing cards. There are no organised group activities. The consultant psychiatrist is available to review patients every two weeks. The NCHD will come to the ward if requested although it was stated that it is sometimes difficult to get an NCHD to attend.

CLINICAL RISK MANAGEMENT

There was one patient restrained by a belt in a chair; this has been discussed with the patients' family and documented in the clinical file. There is no restraint policy. Policies on patients leaving the ward, management of violence and searching patients were all available. There is a pinpoint alarm system in operation. Staff stated that they had received training in control and restraint and in breakaway techniques. Serious incidents are reported but it was stated that no feedback is given to staff on the ward.

UNIT MANAGEMENT

There are no short-term transfers to this ward due to bed shortages. Patients may be transferred to the other elderly care ward for clinical and nursing reasons. According to staff, there is a waiting list for this ward but this list was not available to them. Bedtimes are between 1800h. and 2200h. Meal times are at 0900h, 1230h, and 16.15h, and there are snacks in-between. Visiting times are open.

SERVICE USER INVOLVEMENT

There was a notice board displaying staff names, day and date on the ward. There were no information leaflets available to patients. A complaints policy was available to the nursing staff.

RECORDS

The overall standard of patients' records was poor. The clinical notes were untidy and difficult to follow. There were no six-monthly physical examinations in some files. Some signatures were illegible and no titles of personal were given. The medication sheets were in poor condition. It appears that the prescriptions are rewritten with the original prescription date and then the date that it was rewritten is recorded on a separate part of the card index. Again, signatures were illegible; there was no signature bank available for medical staff. Some prescriptions were not individually dated.

ENVIRONMENT

The physical condition of the ward was very poor. The décor was dull and the rooms were cheerless. There was one large dormitory with a partition dividing it into male and female. There was a veranda for smoking. The clinic room doubles as a relaxation room. The toilets and bathrooms were in poor condition. It should be noted that this ward will close within the next three months and the patients will move to improved conditions.

ST. LUKE'S WARD

Date of inspection: 14th September 2005

Number of beds: 24 integrated

DESCRIPTION

St. Luke's Ward is a single storey building located on the grounds of St. Canice's Hospital. The emphasis of care in the ward is on continuing care of elderly patients although there are a small number of patients under the age of 65 years on the ward. The age range is between 49 and 94 years. There was

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one patient who is on Temporary status on the ward at the time of inspection. All patients are under the care of one consultant psychiatrist.

REFERRAL AND PROCESS OF ADMISSION

There has been one admission to the ward in the past year from a 24-hour supervised hostel. There is a waiting list for this ward.

CARE PLAN

There is a nursing care plan used on the ward. There are meetings between medical and nursing staff every two weeks.

NURSING PROCESS

The model of nursing used on the ward is based on the Orem model. There is no key worker or primary nurse system in operation on the ward. There are three or four nursing staff on duty during the day and two nursing staff on duty at night. However, there are also health care assistants in training in the hospital and sometimes a third year student nurse and two health care assistant replace one of the nursing staff during the day. There are two household staff on duty.

ACCESS TO THERAPY

There is no psychologist, occupational therapist or social worker input to the ward. Patients are referred to these services if required. Aromatherapy is available one day a week. It was stated that there are difficulties in getting the NCHD to attend the ward for routine tasks. The consultant psychiatrist attends the ward every two weeks.

ACCESS TO THERAPEUTIC PROGRAMMES

The occupational therapist does not provide therapeutic programmes to the ward. Three patients attend industrial therapy. There are no needs-based activities. Activities on the ward consist of watching

TV, listening to music, reading newspapers and informal conversations. There are no organised group activities.

CLINICAL RISK MANAGEMENT

There is no seclusion used on the ward. There is no restraint policy. Policies on patients leaving the ward, management of violence and searching patients were all available. There is a pinpoint alarm system in operation. Staff stated that they had received training in control and restraint and in breakaway techniques. Serious incidents are reported and it was stated that feedback is given to staff on the ward.

UNIT MANAGEMENT

There are no short-term transfers to this ward due to bed shortages. Patients may be transferred to the other elderly care ward (St. Joseph's ward) for clinical and nursing reasons. There is one patient who sleeps in the ward every weekend in the bed of a patient who goes home every week-end. According to staff there is a waiting list for this ward but this list was not available to them. Bedtimes are between 1830h and 2300h. Meal times are at 0900h, 1230h, and 1615h, and there are snacks in between meals. Visiting time is open.

SERVICE USER INVOLVEMENT

There was a notice board displaying staff names, day and date and other ward-related information. There were no information leaflets available to patients. A complaints policy was available to the nursing staff on the ward. There was a suggestion box on the ward.

RECORDS

The clinical notes were untidy and one was falling to pieces. There were no six-monthly physical examinations in some files. There were regular reviews by the consultant psychiatrist. Some signatures were illegible and no title of personnel was used. The practice for medication prescriptions is

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that the prescriptions are rewritten with the original prescription date and then the date that it is rewritten is recorded on a separate part of the card index. Again, signatures were illegible; there was no signature bank available for medical staff.

ENVIRONMENT

The ward is quite large and needed redecorating and painting, and some areas needed curtains. There was a large bright day room. There was a well-equipped nurses' office for night time which overlooked a 7-bed dormitory. There were four rooms with four beds, one double room and three single rooms. The sleeping areas all had individual wardrobes, curtains around the beds and personal effects. There was a pleasant quiet room. There were three showers and one bathroom. There was access to the hospital grounds with a seating area. One part of the ward had been recently redecorated and contained an excellent therapy room (not yet in use), showers and toilets.

DEPARTMENT OF PSYCHIATRY

Date of inspection: 14th September 2005

Number of beds: 44 integrated

DESCRIPTION

This is an integrated 44-bed acute unit for general adult psychiatry and old age. On the day of inspection, there were nine patients on Temporary status. The unit is an open facility and six teams have admitting rights.

REFERRAL

The sources of referral are the sector teams, GP, community nurses, day hospital, other hospitals, self-referrals and the addiction teams. Referrals are assessed on the unit and a decision is made regarding admission. The sector team carry out the initial assessment. If the team is not available, the duty NCHD does the assessment. Out of hours, self-referrals present to A&E and are assessed there. In Carlow people present to the day hospital for

assessment and a decision is made there whether to admit to the acute unit in Kilkenny.

PROCESS OF ADMISSION

Children under the age of 16 are not admitted to the unit. There are currently two people in the unit with a moderate intellectual disability where mental illness is the predominant factor. Patients are not admitted solely for detoxification – they receive detoxification in the medical assessment unit. The NCHD carries out an assessment from the sector team wherever possible and the nursing staff may assist on this assessment. A physical examination is carried out and a collateral history is obtained. All decisions to admit to the unit receive a consultant psychiatrists' approval. This is reported as having reduced the number of admissions to the unit. Patients' GPs are not routinely informed of an admission.

During office hours, the CNM3 meets all new admissions and introduces them to the sector nurse whose principal role is to orientate the patient to the unit and to carry out the admission process. Information is given to the patient at this time regarding the unit and their stay within the hospital. Communication with the family is encouraged. A consultant psychiatrist reviews the patient within 24 hours and the initial treatment plan is stored in their notes. Patients are sometimes nursed in night clothes during the day and this is specified in the admission plan and is mainly for safety reasons. The unit is divided into two areas, an acute area and a sub-acute area. If a patient requires a higher level of observation they are nursed in the acute area. There is currently one patient on special observation. The key worker system is based on the sector teams.

CARE PLAN

The admitting nurse implements an admission plan with the patient on admission and a more detailed assessment carried out after 72 hours. Care plans are implemented based on the presenting complaint. Care plans are needs-identified and are predominantly nurse led. There is a referral process to other members of the multidisciplinary teams and there is a weekly sector meeting where each patient is discussed. Care plans are reviewed as required.

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There is currently no documented participation by the patient in the care plan. The patients' discharge is planned from the point of admission. There is a gradual process of discharge from the unit and the plan is discussed at the sector team meeting.

NURSING PROCESS

The unit currently use the Orem Peplau combined model of nursing. This is reported as being appropriate to the needs of the patients and is implemented by the key worker and reviewed by sector nurse. The nursing process does not contain any risk assessment at the present time.

ACCESS TO THERAPY

Psychologists, occupational therapists, social workers and counsellors all have a referral system within the unit and this is reported to be satisfactory. The clinical nurse specialist interviewed reported that the three clinical nurse specialists are involved in facilitating groups but on occasions are allocated to units to cover sickness. This interrupts the continuity of the group programme. There also seems to be some uncertainty about the role of the clinical nurse specialist within the service. There are six consultant psychiatrists who have access to beds within the unit. There are five sector teams and one Psychiatry of Later Life (POLL) team. This is a new team and currently consists of nursing and medical staff. Each multidisciplinary team meets weekly. It was reported that there is a weekly unit round by the consultant psychiatrist, NCHD and the sector nurse. It was not clear why the other members of the multidisciplinary team do not attend this unit round. The physical well-being of the patients is looked after by the NCHD in liaison with St. Luke's Hospital.

ACCESS TO THERAPEUTIC PROGRAMMES

There are three clinical nurse specialists and one basic grade occupational therapist dedicated to delivering a therapeutic programme. The programme is based on a four-week rotation (solutions, coping skills, interpersonal skills and recovery). The occupational therapist documents interventions in the clinical

notes. The clinical nurse specialists do not record any interventions and do not attend multidisciplinary meetings. It was reported that a recent pilot programme for families with first contact to the unit has been discontinued.

ECT

There is an appropriate ECT policy and procedure in place. It was reported that last year there were four people who had ECT and there were 26 applications of ECT. There were appropriate consent forms and information available for the patients.

SECLUSION

There is a seclusion policy in place and the seclusion register was up to date. There is a seclusion facility within the acute area. There was plenty of natural light and appropriate furniture. There was a means to communicate with the patient. It was reported that some people are placed in refractory clothing when in seclusion due to self-harm. There is CCTV monitoring the seclusion room.

CLINICAL RISK MANAGEMENT

There is no clinical risk assessment tool in use on the unit. There is an alarm system in operation and there are policies on the following: alcohol and illegal drugs, patients absconding, the management of violent episodes, and searching patients' belongings and bed areas. There is no policy on rapid tranquillisation and each consultant psychiatrist prescribes individually. There is no policy on giving medication without consent. Mechanical restraint is not used on the unit. There is no formal physical restraint policy although it is referenced in the management of violence policy. Staff receive training in control and restraint techniques which involves de-escalation and breakaway techniques. The staff also receive training in a number of mandatory sessions which include cardio-pulmonary resuscitation, manual handling and fire training. There is also support and funding given for people to undertake long courses and in-house courses. There is no clinical risk assessment documented in the patients' notes. The

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reporting of serious incidents is about to undergo a new procedure and staff are receiving training. It is anticipated that this process will start in November 2005 and it is being implemented by the risk management department in St. Luke's Hospital. It is reported that there are trained staff who facilitate debriefings after serious incidents.

UNIT MANAGEMENT

There are no temporary or long-term transfers to other units due to pressure on beds. Patients are allowed off the unit following a decision at the sector team meeting. The main door to the unit is only locked at night. It was reported that there are some core staff based on the unit. However a number of the staff are allocated to the unit via a central rostering system. This was reported as hindering continuity of care and creating general uncertainty on the management of patients on the unit. There are nine staff on duty during the day, with the three clinical nurse specialists available and a CNM3. There are six staff on duty at night. There is a process of induction for staff and there is administrative support. There is one patient currently awaiting placement elsewhere. Maintenance is carried out within the unit via St. Luke's maintenance department. There are set visiting times to the unit and also set meal times, with drinks provided in between meals.

SERVICE USER INVOLVEMENT

There was information on treatment and therapies available. There is a HSE-wide complaints policy. The unit facilitates a fortnightly community meeting with the patients and there is fortnightly access to advocacy service. Three patients asked to speak to the Inspector on the day of inspection. Two patients focussed on their detention and rights under the 1945 Mental Treatment Act. There were also concerns regarding the lack of access to drinks after 2100h at night. The patients reported that an information leaflet, explaining the service, was only produced on the eve of inspection and that the visitors' room was not always available. The nursing of patients in pyjamas was reported as degrading. Positive comments focussed on the food and cleaning staff.

RECORDS

A number of clients were reviewed in the 25-bed sub-acute area. The notes are an integrated chart with "medical", "nursing" and "others" sections clearly defined. There is no signature bank and a lack of patient identifier on each continuation sheet. The file of a Temporary patient reviewed had its progress notes misfiled. The notes from social workers and occupational therapy were available in some notes. There was evidence of regular consultant psychiatrist review and treatment plans in place in the notes reviewed. There was no signature bank for these staff available. The social worker notes were only initialled. The nursing notes reviewed were in good order, showed evidence of regular recordings. A signature bank of staff was available on the unit. There is a card index system in place. The medication lists were in order. There was no patient receiving ECT, being restrained or being secluded in the sub-acute area on the day of inspection.

ENVIRONMENT

This was a 44-bed acute admission unit situated on the ground floor of a general hospital. The unit is divided into two clinical areas, a sub-acute area and an acute area. The sub-acute area has 25 beds. There were five single rooms, two 4-bed rooms and two 6-bed rooms. The unit opened into an enclosed courtyard. There was access to a quiet room, therapy rooms and an internal smoking room. There was a nursing station, office and clinical room. All were adequate for their purpose. There was CCTV in operation but there was limited signage to notify people of this. The dining area was integrated with acute. The acute area has 19 beds and contains the seclusion area.

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KILKENNY

ALACANTRA RESIDENCE

Date of inspection: 15th September 2005

Number of beds: 10

DESCRIPTION

Alacantra house is located outside Kilkenny city. It is a large two-storey building set on large grounds. It is home to ten residents, with moderate to severe learning disability all discharged from St. Canice's Hospital in 1999. The residents range in age from 36 to 80 years of age.

REFERRAL/PROCESS OF ADMISSION

The residence is under the care of the named consultant psychiatrist. All of the current residents except one came to the house when it opened. There are no active discharges or admissions.

CARE PLAN

The care is primarily delivered by nursing and domestic staff. The consultant psychiatrist reviews the residents every six months. The consultant psychiatrist and NCHD visit fortnightly or as required.

NURSING PROCESS

The Orem Peplau model of nursing has been adapted for the client group. There is no key nurse system but changes are currently being introduced.

REHABILITATION TEAM

There is no rehabilitation team. There is a consultant psychiatrist with responsibility for the clinical care of residents. All residents are reviewed at six-monthly intervals. All residents are registered with a GP that they can visit as required. There is no set rota for annual physical examination.

INVOLVEMENT IN REHABILITATION PROGRAMMES

All residents are involved in a skills programme. This is a module-based programme at different levels for individuals with intellectual disability. It is accredited annually. The residents have a training area located on site in a separate building. The training is delivered by a range of teachers, e.g. art, home management, physical education and aromatherapy. Four residents attend the workshop area. There is an annual awards ceremony to which family and friends are invited. A number of residents participate in the Special Olympics and have competed at all levels. Training for various sports takes place in local facilities. The residence has access to a minibus. There is a new initiative to introduce personal goals for leisure and family contacts.

UNIT MANAGEMENT

The residence is staffed in the daytime by one CNM2, one staff nurse and one domestic staff. One staff nurse is rostered on duty by night. The ethos within the residence is to create a homely atmosphere for the residents.

HOUSE RULES

There are house rules. They are designed by staff and tailored to individual needs. All residents are accompanied on leaving the house. Meals are prepared on site and residents are encouraged to assist in accordance with their ability. All bedrooms are located upstairs. No resident is independently managing his or her own money. All residents have access to pocket money and records are maintained. Residents are currently not paying rent and have received individual letters explaining this. The residents are well known in the community and regularly access sporting and recreational facilities.

SERVICE USER INVOLVEMENT

There is no formal structure in place. Residents are asked to decide on personal goals and they are facilitated by staff. No complaints have been received.

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RECORDS

The charts were in order, showed evidence of six-monthly reviews, and were legible and tidy. The card index system was in order. There was a signature bank for nursing staff on file.

ENVIRONMENT

This is a two-storey large family home. Every attempt had been made to personalise the house and bedroom areas to reflect the personalities and achievements of the residents. There is one single bedroom, three double bedrooms and one triple bedroom. All the bedrooms were located upstairs which could result in problems in the future. All smoking was external. There was a snoezelen room upstairs and staff had been trained in its appropriate use. The house was in good decorative order.

STAFF TRAINING

Staff have received training in challenging behaviour and intellectual disability. There is also access to mandatory training programmes.

KINCORA RESIDENCE

Date of inspection: 14th September 2005

Number of beds: 14

DESCRIPTION

Kincora house is located in a quiet cul-de-sac off the Dublin road in Kilkenny. There are fourteen residents, all of whom had been long-term patients in St. Canice's Hospital. There are nine male residents and five female residents aged between 32 and 79 years.

REFERRAL

Referrals come from the step-down residence or the Department of Psychiatry. There have been no direct referrals. There are three consultant psychiatrists with admitting rights.

CARE PLAN

There is no multidisciplinary care plans in place. There were two discharges last year (2004), one to long-term care and one to a facility for intellectual disability.

NURSING PROCESS

The nursing process consists of two parts, a Peplau Orem care plan and a recently introduced life skills profile on each resident. There is no objective risk assessment on each resident. There is no key nurse system in place.

REHABILITATION TEAM

There is no rehabilitation team. Access to sector team members is by referral. The consultant psychiatrist visits as required. There are regular visits from the sector NCHDs. There is one CNM2 and one staff nurse rostered in the daytime and one staff nurse by night. The staff nurses are not consistently rostered to the residence. There is one cook and one domestic staff member rostered each day.

INVOLVEMENT IN REHABILITATION PROGRAMMES

This is a continuing care residence. Six residents attend a day centre and eight residents attend industrial therapy on the grounds of the hospital. On set days residents are involved in personal care, banking and shopping. There is access to a mini-bus and residents go on organised outings at set times.

UNIT MANAGEMENT

The residence is full and does not accept transfers from other units. The ethos of the residence is one of continuing care. There is no waiting list for admission. There is no method of measuring satisfaction. Maintenance requests are responded to from the hospital maintenance team. There is one cook and one domestic staff member per day. There will be a weekly GROW meeting held in the residence in the near future.

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HOUSE RULES

The house rules are designed by staff. Residents do not have a front door key and are unable to lock bedroom and bathroom doors. All meals are prepared on site. Residents are expected to be involved in set kitchen and dining room tasks. Residents can leave the residence unaccompanied but must be back by 2000h. The routine remains unchanged at the weekends. All monies are collected by staff. Residents are given a daily allowance. Residents access community facilities accompanied by staff.

SERVICE USER INVOLVEMENT

Residents are given verbal information as requested on treatment. Residents do not complain and there is no community meeting. Advocacy services do not attend. Some residents attend GROW meetings in the unit.

RECORDS

The medical and nursing notes reviewed on the day were in order. The card index system was in order. The medication charts had been recently rewritten.

ENVIRONMENT

Kincora Residence is a two-storey building located in a cul-de-sac next door to another high support residence. On the day of the inspection the house was being painted. The toilet and shower areas required to be upgraded and re-tiled. New extractor fans had been fitted in the smoking room. There was a nursing desk located inside the door which gave the impression of a ward. There are eight single bedrooms located down stairs and three double bedrooms upstairs.

STAFF TRAINING

Staff receive mandatory training courses through in service programme from the hospital.

PARK LODGE, CARLOW

Date of inspection: 13th September 2005

Number of beds: 5 male, 4 female

DESCRIPTION

Park Lodge residence is a 9-bed residence two miles outside Carlow town. It was opened in 1992 and is owned by the HSE South Eastern Area. It is under the care of the sector psychiatrist. The age range of residents is between 48 and 83 years. It is planned to move the residents to a new residence in a housing estate in Carlow town within the next year.

REFERRAL AND PROCESS OF ADMISSION

There are few admissions to the residence and the majority of clients have been in the residence since it opened. Any admissions are referred from Clann Nua rehabilitation unit. There are no crisis admissions to the residence and no respite service is provided by the residence.

CARE PLAN

There is a comprehensive care plan system in operation, administered by the nursing staff. There is no multidisciplinary input into the care plan and no multidisciplinary team for the residences. Residents are reviewed regularly by the NCHD. The residents have a yearly quality of life assessment and family satisfaction assessment. Residents are assessed using a life skills profile which is the basis for the individual care plan and each resident is reassessed every three months. The residents are involved in their own care plans. There were no discharges from the residence over the past year.

NURSING PROCESS

As stated, the care plan is administered by the nursing staff. There is one staff nurse on duty during the day and one staff nurse on duty at night. Due to the distance from the town, much of the nurses' time is spent driving clients to and from various venues.

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REHABILITATION TEAM

There is no multidisciplinary rehabilitation team with responsibility for the residence. There are no team meetings in the residence. Residents attend a regular outpatients department for review. Residents have their own GPs.

INVOLVEMENT IN REHABILITATION PROGRAMMES

All residents are involved in activity or rehabilitation training programmes. There is transport for the residence.

UNIT MANAGEMENT

There are no temporary transfers to the residence due to bed shortages. There is one household staff five days a week. Residents have their own bank accounts and bank books. The residents are able to collect their own social welfare allowances and buy their own clothes. A set amount of money is donated by each resident for utilities and food. Staff stated that there are some difficulties in obtaining maintenance for the residence. There are management meetings between staff in all residences.

ETHOS

There was care planning and elements of rehabilitation in the residence. However, most of the residents were receiving continuing care with little prospect of moving to lesser supervision due to their increasing frailty and age.

HOUSE RULES

Any changes in residence management are discussed with the residents and there are regular unit meetings. There are no formal house rules. Each resident is on a rota for household chores and meals are shopped for and cooked by the residents. There is free access to the kitchen. There are no set bedtimes. All residents require transport to town to access community facilities such as hairdressers, shops and

pubs and also to any rehabilitation and activation programmes. Residents do not have their own front door key.

SERVICE USER INVOLVEMENT

Residents were fully aware of their programme and were involved in their assessments.

RECORDS

The clinical files were in excellent condition and all residents had been reviewed within the previous few months. Medications are prescribed initially by the psychiatrist and then prescribed by the residents' general practitioner. Some medication sheets needed to be rewritten.

ENVIRONMENT

The residence is in a pleasant country location with extensive gardens. However there are no community amenities within walking distance. There was a comfortable sitting room. There was open access to the kitchen. The dining room required renovation. The bedrooms were personalised. There was an adequate number of toilets and showers and bathrooms. One bathroom was newly decorated. There was plenty of personal storage for clients. Overall the residence was run down and required urgent redecorating. However, it is planned to move the residence to a new residence shortly.

BEECHWOOD DRIVE, CARLOW

Date of inspection: 13th September 2005

Number of beds: 6 male 3 female

DESCRIPTION

Beechwood Residence is a 9-bed residence in a housing estate in Carlow town. It was opened in 2001 and is owned by the HSE South Eastern Area. It is under the care of the sector psychiatrist. There is an emphasis on care planning and rehabilitation in the residence. The age range of residents is between 28 and 71 years.

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REFERRAL AND PROCESS OF ADMISSION

There are very few admissions to the residence. All admissions are referred from Clann Nua rehabilitation unit. There are no crisis admissions to the residence and there is no respite service provided by the residence.

CARE PLAN

There is a comprehensive care plan system in operation which is administered by the nursing staff. The residents have a yearly quality of life assessment and there is also a yearly family satisfaction questionnaire. Residents are assessed using a life skills profile that is the basis for their individual care plan and are reassessed every three months. The residents are involved in their own care plan. There is no multidisciplinary input into the care plan and there is no multidisciplinary team for the residences. The residents are reviewed regularly by the NCHD. There were no discharges from the residence over the past year.

NURSING PROCESS

The care plan is administered by the nursing staff. There is one staff nurse on duty during the day and one staff nurse on duty at night.

REHABILITATION TEAM

There is no multidisciplinary rehabilitation team with responsibility for the residence. There are no team meetings in the residence. Residents attend the outpatients department for review.

INVOLVEMENT IN REHABILITATION PROGRAMMES

All residents are involved in activity or rehabilitation training programmes. There is transport for the residence.

UNIT MANAGEMENT

Residents have their own bank accounts and bank books. Most residents are able to collect their own social welfare allowances and buy their own clothes. There is a set amount of money donated by each resident for electricity and food. There are no temporary transfers to the residence due to bed shortages. There is one household staff five days a week. There are management meetings between staff in all residences. The staff were unaware if there was a waiting list for the residence. There are no difficulties in obtaining maintenance services for the residence. There is an emphasis on care planning and rehabilitation in the residence. However, staff felt that only one resident is suitable for moving from the residence to lesser supervision.

HOUSE RULES

There are no formal house rules. Any changes in residence management are discussed with the residents and there are regular unit meetings. Each resident is on a rota for household chores and meals are shopped for and cooked by the residents. Residents do not have their own front door key. There is free access to the kitchen. There are no set bedtimes. Most of the residents require transport to access community facilities such as hairdressers, shops and pubs.

SERVICE USER INVOLVEMENT

Residents were fully aware of their programme and were involved in their assessments. However, the residents did not sign their own care plans.

RECORDS

Medications are prescribed initially by the psychiatrist and then prescribed by the resident's GP. Some medications sheets needed to be rewritten. The clinical files were in excellent condition and all residents had been reviewed within the previous few months.

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ENVIRONMENT

The residence is a very pleasant residence in the middle of a housing estate. There was a comfortable sitting room, a dining room and a kitchen that was open to residents. There was a single and double bedroom downstairs and two single rooms and two double rooms upstairs. All rooms have wash-hand basins. All rooms had personal possessions and were nicely decorated. There was a small garden and patio area.

COURT VIEW, CARLOW

Date of inspection: 13th September 2005

Number of beds: 6 male 3 female

DESCRIPTION

Court View Residence is a 9-bed residence in Carlow town. It was opened in 1990 and is owned by the HSE South Eastern Area. It is under the care of the sector psychiatrist. The age range of residents is between 33 years and 70 years.

REFERRAL AND PROCESS OF ADMISSION

There are few admissions to the residence and none in the last year. All admissions are referred from Clann Nua rehabilitation unit or from other residences. There are no crisis admissions and no respite beds in the residence.

CARE PLAN

There is a comprehensive care plan system in operation in all the residences which is administered by the nursing staff. Patients are assessed using a life skills profile that is the basis for the individual care plan and is re-assessed every three months. The residents also have a yearly quality of life assessment and there is a yearly family satisfaction questionnaire. Residents are involved in their own care plans. There is no multidisciplinary input into the care plan and there is no multidisciplinary team for the residence. The NCHD regularly reviews residents. There were no discharges from the residence over the past year.

NURSING PROCESS

As stated, the care plan is administered by the nursing staff. There is one staff nurse on duty during the day and one staff nurse on duty at night.

REHABILITATION TEAM

There is no multidisciplinary rehabilitation team with responsibility for the residence. There are no team meetings in the residence. Residents attend the outpatients department for review and nurses accompany the residents to the clinic.

INVOLVEMENT IN REHABILITATION PROGRAMMES

All residents are involved in activity or rehabilitation training programmes. There is transport for the residence and residents are often taken on outings.

UNIT MANAGEMENT

There are no temporary transfers to the residence due to bed shortages. Resident have their own bank accounts and bank books. Most residents are able to collect their own social welfare allowances and buy their own clothes. There is a set amount of money donated by each resident for food and utilities. There are management meetings between staff in all residences. The staff were unaware if there was a waiting list for the residence. There is one household staff on week days. There are no difficulties in obtaining maintenance services for the residence. Staff did the residents' laundry.

ETHOS

There was an emphasis on care planning and rehabilitation in the residence. It was felt that a small number of residents would eventually be able to move to accommodation with less supervision. All policies and procedures were available and were extremely comprehensive. Nurses did not wear uniforms.

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HOUSE RULES

There are no formal house rules. Any changes in residence management are discussed with the residents and there are informal unit meetings. There is free access to the kitchen. Each resident is on a rota for household chores and meals are shopped for and cooked by the residents. The residence is within walking distance of community facilities. However, a hairdresser comes to the unit for some residents. Residents do not have their own front door key. There are no set bedtimes.

SERVICE USER INVOLVEMENT

Residents were fully aware of their programme and were involved in their assessments.

RECORDS

Medications are prescribed initially by the psychiatrist and then prescribed by the resident's GP. The medication sheets were satisfactory. The clinical files were satisfactory and all residents had been reviewed within the previous few months.

ENVIRONMENT

The residence is a very pleasant comfortable residence in the middle of Carlow town. There was a homely kitchen and dining area. There was also a more formal dining room that was used for special occasions and as a visitors' room. There was a smoking area outside. The sitting room was comfortable and pleasantly decorated and there was also a quiet room with a TV. The bedrooms were double and single and there was one triple room. All were comfortable with wardrobes and personal possessions. There was also a laundry room.

GREENBANKS, CARLOW

Date of inspection: 13th September 2005

Number of beds: 14

DESCRIPTION

Greenbanks is a 14-bed crisis/respite house with 24-hour nursing staff supervision. The residence is situated on the outskirts of town and opened in 2003. On the day of inspection, there were eight residents.

REFERRAL

The sources of referral to Greenbanks are the Department of Psychiatry, Kilkenny, the Day Hospital in Carlow, and outpatients clinics. The process of referral is a referral form which is completed over the phone. All people referred to Greenbanks are known to the mental health services. Out of hours, the on-call primary care system carries out the assessments.

PROCESS OF ADMISSION

There is an admission policy in existence and the resident is usually reviewed the next working day. The only exclusion from admission is intoxication. The three main reasons for admission to Greenbanks are post-discharge from hospital, crisis admission and planned respite. On admission a mental state examination is carried out. The nursing staff carry out an assessment which leads to a plan of care. All residents are registered with a local GP. The decision to admit to Greenbanks is made by a consultant psychiatrist and senior nurse. The resident's family is notified on admission and the consultant psychiatrist reviews the resident weekly. The initial treatment plan is documented in the nursing and medical notes. There is no key worker system in operation. The CNM2 evaluates the care plans in conjunction with the staff nurses on a weekly basis. The main reason given for not having a key worker system is the central rostering system.

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CARE PLAN

Care plans are nurse led and there is a referral procedure to other disciplines of the multidisciplinary team. There is no dedicated rehabilitation team. Greenbanks has access to sector teams in Carlow who have all elements of a core multidisciplinary team. Nursing care plans have goals and objectives identified and they are reviewed weekly by the CNM2. There is no documented participation by the resident in the care plan.

The process of discharge is planned. Residents are given as much notification as possible. There is currently one person awaiting alternative accommodation. All relevant parties are notified on discharge.

NURSING PROCESS

Greenbanks use the combined Orem Peplau nursing model which is described as appropriate to the needs of the resident. There is no key worker system and no formal risk assessment tool is used. It was reported that any risk is identified by the consultant psychiatrist in their assessment. Staff are identified by name badges.

REHABILITATION TEAM

There is no dedicated rehabilitation team. Greenbanks has access to two sector teams in Carlow. The referral system works reasonably well though there can be a waiting list for some counselling therapies. Consultant psychiatrists visit Greenbanks twice a week and are also available via phone contact and the NCHD visits on a regular basis. The residents have access to a dentist, chiropodist and optician in the community and a home economics teacher visits weekly.

INVOLVEMENT IN REHABILITATION PROGRAMMES

There is evidence of needs-based individual programmes. Residents are involved in a range of activities which occur off site. Residents are primarily in this facility for crisis management or pre-arranged respite. Residents who have a deficit in relation to

employment, finance or housing have access to the multidisciplinary team and a supported training officer where these issues can be addressed.

UNIT MANAGEMENT

The house is not used for any other purposes although there is an advocacy meeting held monthly. All the staff are trained and there are student nurses on the unit. The central rostering system allocates people on a daily basis and this interferes with continuity of care. The ethos of the residence is to support and provide rehabilitation to the residents. There is a formal process of induction for residents and for new staff and students. There are appropriate policies and procedures present. All maintenance is carried out by the maintenance department at St. Dymphna's Hospital.

HOUSE RULES

There are house rules in place which pertain to respecting people's space and privacy and alcohol and drug use. Visiting times are flexible. Residents can lock the bathroom and their bedroom doors and the staff have overriding keys. Residents are allowed to leave the accommodation unsupervised but they are asked to let staff know when they are returning. It is reported that they are not required to be out during the day. Meals are prepared within Greenbanks by the housekeeper with the assistance of some of the residents. Residents are involved in the menu planning and shopping and can make drinks and snacks. Residents are not required to go to bed or get up at a set time. The majority have single rooms, there is only one double room in the premises. All residents manage their own finances and are advised to hand in any large sums of money for safekeeping. It is reported that the facility is fully integrated with the local community and the residents attend the local cinema, bowling club, shops, pubs and other facilities.

SERVICE USER INVOLVEMENT

There is an information leaflet available for all the residents. The information leaflet is informative and a

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positive example. There is also an information board in the premises. All the residents have the right to vote and they are encouraged to do so. There is a complaints policy within the HSE area. There is a community meeting held with the residents and staff and there is access to an advocacy meeting on a monthly basis.

RECORDS

Residents do not access their files and they are advised to request access to their notes via the head office in Kilkenny. The residents' name and ID number is on all pages and the files are reasonably tidy and legible. There are combined files and each discipline has a section within the notes to write up their interventions. They contain progress reports and a treatment plan. All interventions are signed and dated. Nursing care plans are reviewed on a weekly basis. Drug cards are all appropriately signed and dated and it was reported that no resident is on a self-medication programme. The policies and procedures within the mental health services are subject to a quality measure audit, which is the ISO 9002. It was reported by staff that a number of the procedures are not appropriate for Greenbanks.

ENVIRONMENT

The residence had a very pleasant environment that was clean and appropriately decorated. Staff ensured that people had the right to privacy and the majority of people stay in a single room. The unit consisted of a number of single bedrooms and one double bedroom, two lounges, one of which is smoking, a relaxation lounge, a kitchen, sufficient bathrooms and toilets, a meeting room and an office. There was also a nice garden area and a courtyard.

CLINICAL RISK MANAGEMENT

There is evidence of clinical risk management policies and any serious untoward incidents are recorded on appropriate forms which are sent to the Assistant Director of Nursing. There is telephone follow-up.

STAFF TRAINING

There is no specific training regarding rehabilitation and this was identified as being needed. The mandatory training is facilitated via the central rostering system.

CLAN NUA

Date of inspection: 13th September 2005

Number of beds: 7 integrated, 1 crisis bed

DESCRIPTION

Clan Nua is located in St. Dymphna's Hospital and is an open unit. The function of the unit is to provide rehabilitation and a crisis response. All the residents in the unit are discharged.

REFERRAL TO UNIT

The source of referral is the two sectors teams in Carlow and the process of referral is through the multidisciplinary team meetings. The mechanism of assessment prior to admission is a gradual introduction which encompasses visits for the residents and family and sharing of information about the unit. When residents are ready to be transferred, they are formally admitted.

PROCESS OF ADMISSION

There are some people with a moderate intellectual disability admitted to the unit who remain under the care of the sector consultant psychiatrist. People are admitted for social crisis. Each resident is given at least a month to settle in and become familiar with the programme. The staff observe the resident during this process and undertake a number of assessments. The assessments include the Life Satisfaction Scale and the Lancashire Quality of Life Profile. Each resident is registered with a local GP. Decisions to admit residents are taken by the team. Family members are involved where possible. A satisfaction questionnaire is sent out each year to relatives. It is also part of the Lancashire Quality of Life process to involve family members. The initial treatment plan is

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documented in the notes. Four of the regular members of staff are responsible for carrying out the assessments and care plans.

CARE PLAN

The care planning process is nurse led. Needs are identified through the life skills profile and other members of the multidisciplinary team are involved as required. Goals and objectives are identified but there is no identified key worker. As mentioned earlier there are four regular staff who oversee the process of care planning. A review of care plans takes place every three months. There is no documented participation by the resident although staff reported that there was a lot of verbal interaction. When it is deemed appropriate for a resident to leave Clan Nua a planned gradual process is put in place. All relevant parties are informed and a support network is established.

ACCESS TO THERAPY

Access to a psychologist, occupational therapist and social worker is through a referral system to the sector teams. Other counsellors are accessed through the sector team. The sector consultant psychiatrist maintains responsibility for the residents during their stay in Clan Nua and reviews take place in the outpatients department as required.

ACCESS TO THERAPEUTIC PROGRAMMES

There is evidence of a needs-based programme. All residents within the unit have an active programme. It was reported that they try to structure as much time as possible for the residents. They attend various skills programmes aimed at re-integrating people back into the community. They also attend some of the facilities on site in St. Dymphna's Hospital, such as Skills Base, the Dolmon Centre and the Dove Centre. Some of the residents have obtained voluntary work within the community.

CLINICAL RISK MANAGEMENT

There are all the appropriate policies in place within the unit and they are audited on a six-monthly basis as part of the audit system within the Carlow Mental Health Services. This is the ISEN ISO 9002 System. Staff receive training in control and restraint techniques, which include de-escalation and breakaway techniques. They also carry out other mandatory training such as cardio-pulmonary resuscitation and lifting and handling. There is a preceptorship course to provide student placements and there are a number of courses run by the faculty of nursing. There are some elements of risk assessment in the Lancashire Quality of Life Profile and the Life Satisfaction Scale. All serious incidents are recorded on the appropriate forms and sent to the Assistant Directors of Nursing and then on to the risk management department.

UNIT MANAGEMENT

There are no temporary transfers out of the unit although they may temporarily admit a patient from Greenbanks. It was reported that this rarely happened. The unit is used occasionally for other day patients on a sessional basis. It was reported that three of the current residents could move on to a lower support hostel with supervision if it was available. All maintenance is carried out by the maintenance department in St. Dymphna's Hospital. Visiting times are flexible. Meal times are set and are prepared by the residents. There is also free availability of snacks and drinks.

SERVICE USER INVOLVEMENT

There is information available on treatment therapies, rights and information about the service. There is a HSE-wide complaints policy and complaints are followed up appropriately. Relatives are sent an annual questionnaire regarding their satisfaction with the service and are also encouraged to communicate with staff on a regular basis. There are unit community meetings with the residents to obtain their views regarding the service. There is an advocacy officer available within the hospital on a fortnightly basis.

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RECORDS

The medical information on the residents is documented in the out patients' notes. They are records of reviews of the residents and they are signed and dated. The frequency of review varies depending on the need of the resident. Nursing files contain the Life Skills Questionnaire reviews which lead to care plans and they are reviewed on a three-monthly basis. Medication charts were all satisfactory.

ENVIRONMENT

This was an 8-bed unit in the grounds of a psychiatric hospital. The unit was in a good state of repair and decorative order. There was appropriate ventilation, light and noise levels. There were numerous information boards containing up to date and relevant information. There was a dedicated visitors' area and access to a garden. All bedrooms were single and they had wardrobe space and they were nicely decorated. The rooms were of a good size and afforded maximum privacy to the residents. The toilets and bathrooms were freely accessible and in good decorative order. The dining area was downstairs from the unit with space for one sitting and it was integrated. The residents prepared the meals in this kitchen/dining area. The lounge areas contained comfortable seating and were in good decorative order. There was access to TV, video, radio, newspapers and books. The nurses' station was in a central location. It was a large room with space for report writing. It was confidential, accessible and had a telephone and IT system. The clinical room was also in this office and contained all the appropriate medical equipment and drug storage.

MOUNT LACKEN, KILKENNY

Date of inspection: 14th September 2005

Number of beds: 10 integrated

DESCRIPTION

This is a 10-bed community residence with 24-hour nursing staff supervision situated close to town. The accommodation is leased by the HSE from the Mental Health Association. It was opened in 1989 and on

the day of inspection there were five male residents and five female residents.

REFERRAL

The source of referral is the Department of Psychiatry and in the past St. Canice's Hospital. The process of referral is through the sector team and the Department of Psychiatry.

PROCESS OF ADMISSION

There is an admission policy in place however the population in this hospital is fairly static. A number of the residents came from St. Canice's long-stay wards and may be deemed to have reached their optimum level of independence. The residents receive a review every two to three months by the consultant psychiatrist. Each resident is registered with a GP; some access the GP independently while others need to be accompanied. The decision to admit to the residence is made by the consultant psychiatrist. Family contact is encouraged wherever possible. The treatment plan is documented in the case notes.

CARE PLAN

There is a nurse led care planning system. They are needs identified and indicate goals and objectives to be achieved. There is only one member of staff working within the residence so they are responsible for reviewing the care plans which are done on a three to six-monthly basis.

NURSING PROCESS

The nursing model is the Orem Peplau combined model which is reported as being appropriate to the needs of the residents and is implemented by the nursing staff.

REHABILITATION TEAM

There is no dedicated rehabilitation team in the Kilkenny services. There is access to psychologists,

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occupational therapists, social workers and counsellors through the sector teams. The residents also have access to a chiropodist, hairdresser, dentist and optician.

INVOLVEMENT IN REHABILITATION PROGRAMMES

Each resident is involved in an individual programme. The programmes are designed to meet individual needs and are a combination of attending to personal hygiene, carrying out household chores and attending the industrial therapy and occupational therapy departments within the area. It was also reported that two of the residents are over retirement age and have therefore retired.

UNIT MANAGEMENT

There are no temporary or long-term transfers from this residence to accommodate bed pressure elsewhere. All staff within the residence are qualified and there is one staff on duty. The ethos of the residence is to provide rehabilitation and integration in the community. There were appropriate policies and procedures present. Maintenance is carried out by St. Canice's maintenance department and it was noted that the residence is in need of redecoration.

HOUSE RULES

House rules are detailed in the unit profile and are based on respecting people's space, privacy, smoking, and alcohol and drugs. Visiting times are flexible. Residents are allowed to leave the residence unsupervised and are asked to inform the staff what time they are going out and what time they are coming back. They are not required to be out during the day.

Meals are prepared on site by the household staff with some assistance from the residents. Residents are not required to go to bed at any set time but are required to be up for breakfast in the morning. Staff supervise the management of finances and the residents are given pocket money on a daily basis. All financial transactions are recorded in the appropriate documentation. Residents are not asked to pay for the furniture or fittings for the residence. The

residents buy their own clothes in local shops and have access to the utility room. The residents access community amenities such as shops, pubs, GAA, cinema and local church. All facilities are within walking distance.

SERVICE USER INVOLVEMENT

There is information available on treatment therapies and a unit profile. All the residents have the right to vote. There is a HSE-wide complaints policy and information on complaints is available.

RECORDS

The residents' records were all legible and up to date. Nursing care plans are regularly reviewed and the progress reports and treatment plans are in place. A consultant psychiatrist reviews the patients on a two to three-monthly basis. The medication cards were all appropriately signed and dated. It was reported that none of the residents are currently on a self-medicating programme.

ENVIRONMENT

It was a pleasant building situated near the centre of the town. It was noted that the residence needed some redecoration and the staff reported that this had been agreed. Furniture and fittings within the residence seemed appropriate and comfortable. The residence consisted of two lounge areas, one smoking and one non-smoking. There was a mixture of single and double bedrooms, a kitchen, dining area and toilets and bathrooms. There was a large garden to the rear of the property.

CLINICAL RISK MANAGEMENT

There were no policies regarding clinical risk management. The serious untoward incidents are recorded on the appropriate forms and sent to the Assistant Director of Nursing's office.

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LISMORE RESIDENCE

Date of inspection: 14th September 2005

Number of beds: 10

DESCRIPTION

Lismore Residence is a 10-bed residence with 24-hour nursing staff supervision located off the main Dublin road, 1.5 miles from town. The residence opened in 1991; in 2003 six patients were transferred from the Department of Psychiatry. The residence has a higher nurse-resident ratio due to the challenging behaviours of the residents.

REFERRAL

There are three consultant psychiatrists with admitting rights to the residence. There have been no recent admissions. There is no written admission policy. All residents are discharged. One resident is a discharged on trial on a Temporary certificate under the Mental Treatment Act 1945. On the day of inspection, he had been re-admitted to the Department of Psychiatry to fulfil the legal requirements under the 1945 Mental Treatment Act. A decision should be made by the clinical team regarding his status. It is unacceptable that this patient continues to be admitted and discharged on trial on a continuous basis.

CARE PLAN

There is no multidisciplinary team care plan. The consultant psychiatrist completes six-monthly reviews, usually in the sector day hospital. All residents are registered with a local GP and are accompanied on visits by a staff member. There was one death last year, no discharges and no resident is currently waiting a lower level of accommodation.

NURSING PROCESS

The nursing process is divided into two parts, Peplau Orem care plan and a recently introduced life skills profile on each resident. There is no objective risk assessment on each resident. There is no key nurse system in place.

REHABILITATION TEAM

There is no rehabilitation team. Access to sector team members is by referral. The consultant psychiatrist visits as required. There are regular visits from the NCHD. There is a high ratio of nursing staff, one CNM2 and three staff nurses each day. One resident is physically dependent and has one-to-one nursing during the day. All nursing staff carry personal alarms. At night there are two staff nurses.

INVOLVEMENT IN REHABILITATION PROGRAMMES

A number of residents attend industrial therapy and the day centre on the grounds of the hospital. Other residents are involved in an individual programme in the house.

UNIT MANAGEMENT

The residence is full and does not accept transfers from other units. The ethos of the residence is one of continuing care. There is no waiting list for admission. There is no method of measuring satisfaction. Maintenance requests are responded to from the hospital maintenance team. There is one cook and one domestic staff member per day.

HOUSE RULES

All house rules are designed by staff and all residents must sign. Residents do not have a front door key and are unable to lock bedroom or bathroom doors. All meals are prepared on site and residents do not have access to the kitchen and are not involved in developing cooking skills. Some residents assist with weekly shopping but choice is not available. All residents have their money collected by staff and money is allocated daily. Residents do not have independent access to the laundry room. There is a petrol station and shop nearby and residents walk to town and access community facilities. The residence has access to a minibus.

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SERVICE USER INVOLVEMENT

Residents are given oral information as requested on treatment. Residents do not complain and there is no community meeting. Advocacy services do not attend the unit.

RECORDS

The chart is subdivided in medical and nursing notes. The charts reviewed were in order and showed evidence of regular review. There is a need to establish documentation standards and to introduce signature banks for all staff that would be available on site. All residents should be reviewed on site by the consultant psychiatrist and there should be active six-monthly case reviews. The life skills profile files were in order and showed evidence of regular review. No residents are self-medicating. The card index system was in order. The medications had all been rewritten recently.

ENVIRONMENT

Lismore Residence is a two-storey building that had an extension added. It was set in a cul-de-sac on extensive grounds. A small piece of the garden had a vegetable plot and a number of residents were involved in the project. On the day of inspection, the residence was being repainted internally and externally. The house has an internal smoking room and an external smoking room. There are six single rooms and two double rooms.

STAFF TRAINING

Staff receive mandatory training courses through an in-service programme from the hospital.

SERVICE USER COMMENTS

Two residents asked to speak to the Inspector during the visit. The first resident wanted his daily allowance reviewed. The second resident wanted to be allowed to go home. Both requests were brought to the attention of the CNM on the day.

MILLENNIUM COURT, KILKENNY

Date of inspection: 15th September 2005

Number of beds: 7 integrated

DESCRIPTION

This is a seven-bed community residence with 24-hour nursing staff supervision situated close to town. It was opened in 2002 and provides rehabilitation and a homely environment for seven people.

REFERRAL

The main sources of referral are the Department of Psychiatry and other residences within the area. Referrals are to the sector team and consultant psychiatrist, which meet with the staff in the residence and the community Assistant Director of Nursing to make decisions on admission.

PROCESS OF ADMISSION

There is no specific admission policy. People with recent history of violence are excluded due to the close proximity to other houses. The main reason for admission is for residents to undertake a rehabilitation programme. On admission the residents have a full assessment, including a physical examination. The consultant psychiatrist reviews each of the residents every two to three months and can also be seen more frequently in outpatients. The decision to admit a resident to the residence is made by the consultant psychiatrist and community Assistant Director of Nursing in conjunction with the residence team. The initial transfer is a gradual process which includes visits and an overnight stay and general orientation to the residence. Family contact is encouraged. The initial treatment plan is documented in the notes. There is only one member of staff on duty who undertakes the role of key worker.

CARE PLAN

Care plans are implemented following a life skills assessment. This is deemed to be appropriate and involves all persons in meeting the needs of the

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resident. Care plans are reviewed on a regular basis. The residents do not sign the care plans. When a resident is ready to leave the residence they are discharged on a gradual basis with aims and objectives established. It was reported that two people currently in the residence could move on to a lower support accommodation.

NURSING PROCESS

The unit have adopted the Orem Peplau combined model of nursing. It is described as appropriate to the needs of the residents and is implemented by the nursing staff. There are some elements of a risk assessment contained in this model. Staff are identified by name badges.

REHABILITATION TEAM

There is a referral system for psychologist, occupational therapist, social worker and counsellor input through the sector teams. The consultant psychiatrist is available to see people in crisis but regularly reviews every two to three months. Residents are usually accompanied to the GP.

INVOLVEMENT IN REHABILITATION PROGRAMMES

There is evidence of a needs-based programme. The residents are involved in programmes to move on to lower levels of support. On the day of inspection, all the residents were attending day services, as they do on a regular basis.

CLINICAL RISK MANAGEMENT

There is some evidence of risk assessments in the patients' files. Any serious incidents are recorded on appropriate forms and sent to management.

UNIT MANAGEMENT

There are always qualified nursing staff on duty. The staff are provided through a central rostering system although there are two CNM2s based permanently

within the residence. There is one household staff. The ethos of the residence is to promote rehabilitation and independence. There is a formal process of induction for residents and staff and the dress code is casual. There are appropriate policies and procedures present. The waiting list is managed through the sector team meetings. Maintenance is provided by the HSE.

HOUSE RULES

House rules are standard regarding smoking, alcohol and respecting people's space. Visiting times to the residence are flexible. Residents do not have a front door key although this may be considered by the staff. They can lock the bathroom doors and their bedroom doors and there is an override lock facility. Residents are allowed to leave the residence unsupervised and they are asked to inform staff when they are going out and what time they will be back. They are not required to be out during the day. Meals are prepared on site by the household staff and residents are involved in menu planning. Residents have access to the kitchen to make drinks and snacks. Residents are not required to go to bed at set times at night and are encouraged to be up in the morning to attend their programmes. They all have single rooms. The residents do not manage their own finances. They are given pocket money on a daily basis. There is a policy on financial management of residents' money. Money is collected by the staff and given to residents daily. Residents are encouraged to buy their own clothes in local shops and they have access to a utility room to undertake their own washing. It was reported that the residents are fully integrated with the local community. They are very close to town and visit various shops, pubs, GAA and there is a social fund of €10 per week which they all contribute to which is spent on outings and holidays.

SERVICE USER INVOLVEMENT

There is information on treatment and therapies available. All the residents have the right to vote. There is a complaints policy in place which is a HSE wide policy. There is a residence community meeting between the staff and residents.

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RECORDS

Residents do not access their own file or write in them. The resident's name and ID number is on all the pages. The files are legible and tidy and the full name and title of the person is stated. All entries are signed and dated. If other healthcare professionals are involved, they write in the files. There is a treatment plan which is dated, and also progress reports. Nursing care plans are up to date and regularly reviewed. There are currently no residents on a self-medication programme. All the drug and index cards are signed, dated, legible and use generic names.

ENVIRONMENT

There was a regular maintenance programme in place provided by the HSE. The hygiene and décor of the unit were of a high standard and there was comfortable and appropriate furniture. All the rooms were single, privacy and dignity was maintained. The residence consisted of two houses joined together which had seven bedrooms, two lounge areas with one for smoking, a dining area, kitchen, sufficient bathroom and toilets, a utility area and a garden.

STAFF TRAINING

There is training available for nursing staff and it was reported that the nurse managers are supportive of people undertaking courses.

ALTAMOUNT

Date of inspection: 14th September 2005

Number of beds: 13

DESCRIPTION

Altamount is a 13-bed residence with 24-hour nursing staff supervision, with beds designated for crisis response, rehabilitation and transfer from the Department of Psychiatry. The residence is situated near the town and opened in 1993. On the day of inspection, there were seven male residents and six female residents.

REFERRAL

The sources of referral to the residence are the Department of Psychiatry and the sector teams in the community. Referrals are sent to the residence, or the community mental health nurse contacts the residence. There is a close liaison between the residence, the Department of Psychiatry and the community teams.

PROCESS OF ADMISSION

There is an admission policy in existence. All of the residents that are admitted to the residence are discharged. The main reason for admission is for rehabilitation management of a crisis. On admission, the resident is orientated to the unit and information is obtained from the relatives. The programme is explained, as are the rules of the house. All residents are registered with a local GP. The decision to admit is made by the sector team. The NCHD visits on a weekly basis and the residents are reviewed via the sector team. There is no key worker system.

CARE PLAN

There is no formal care planning process in operation within the residence. Needs are identified on admission and progress notes are written on a continual basis. There are no specific care plans identified. When a resident is deemed suitable for leaving, a planned, gradual process is implemented with close liaison with the community mental health nurse. There are currently two residents awaiting placements in group homes. All relevant parties are notified when a resident is discharged.

REHABILITATION TEAM

There is no dedicated rehabilitation service team within the Kilkenny area. Psychology, occupational therapy, social work and counsellors are available through the sector teams.

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INVOLVEMENT IN REHABILITATION PROGRAMMES

There is evidence of a needs-based individual programme. Residents are involved in programmes to move to lower levels of support or to overcome a particular crisis.

CLINICAL RISK MANAGEMENT

There is no evidence of any risk assessment being undertaken. Serious untoward incidents are recorded on appropriate forms.

UNIT MANAGEMENT

There are no temporary or long-term transfers to other units due to pressure on beds. The residence is not used for any other purpose. All staff within the residence are qualified and there are two staff on duty during the day and two at night. The unit is part of a central rostering system, resulting in a lack of continuity of staff. There are two household staff on duty. The ethos of the residence is to promote rehabilitation and crisis intervention. There is a formal process of induction for residents and staff and there are appropriate policies and procedures present. The dress code is casual. The waiting list is managed through the sector teams and based on a priority basis. Maintenance is carried out by the St. Canice's Hospital maintenance department.

HOUSE RULES

There are house rules in place and they are based on alcohol, drugs, respecting people's privacy and space, and smoking. Visiting times are flexible, although visitors are asked to avoid meal times. Residents can lock bathroom and bedroom doors but do not have a front door key. Residents are allowed to leave unsupervised but are asked to let staff know when they are returning. It was reported that most of the residents have mobile phones and so are contactable. Residents are not required to be out during the day.

Meals are prepared on site by the kitchen staff. Residents are not involved in menu planning or shopping. Residents are not required to go to bed or get up at set times although they are all set to be up

for 0900h. All the bedrooms are single. Some of the residents manage their own finances. Staff collect the benefits and give out money on a daily basis for the others. All transactions are recorded in individual books and relatives are kept informed of such transactions. Residents buy their own clothes in the local shops and have access to the utility room. It was reported that there was good integration with the community services.

SERVICE USER INVOLVEMENT

There are no information leaflets on treatment or therapies. There is some information available on rights, in particular the recent introduction of the new charges. All residents have the right to vote and are encouraged to do so. There is a HSE-wide complaints policy. Complaints are followed up appropriately. There is no access to advocacy services.

RECORDS

The files of the residents are tidy and up to date and in good order. All entries have the full names and titles of personnel and are signed and dated. If another health professional assesses the resident the nursing staff document this in the file, but there is no written account of the assessment. The nursing section of the notes contains no care plans. There is an initial assessment and progress notes. Medication cards are all appropriately signed and dated. There is nobody on a self-medication programme.

ENVIRONMENT

There is regular on-going maintenance provided by St. Canice's maintenance department. The unit was clean and tidy and in good decorative order. It was all on the ground floor and consisted of lounges, single rooms, kitchen, toilets, bathrooms, utility area and a unit office.

STAFF TRAINING

It was reported that staff are in receipt of training both in house and externally. Funding and time off the unit is available for staff to undertake degree courses.

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CAOMHNÚ, KILKENNY*Date of inspection: 15th September 2005**Number of beds: 21 integrated***DESCRIPTION**

This is a 21-bed community residence consisting of three bungalows with seven bedrooms in each. The service provides rehabilitation for people with moderate to severe intellectual disability. On the day of inspection, there were three residents with Person of Unsound Mind (PUM) status on the unit.

REFERRAL

This unit opened in 2001 following the closure of wards in St. Canice's Hospital. Twenty-one residents moved from the hospital to this purpose-built community residence. The residents are based here permanently and there are plans in the future to develop a rehabilitation team to oversee placement of people with an intellectual disability in community residences.

CARE PLAN

Care plans on the unit are nurse led, identify people's needs, and involve all appropriate persons in meeting these needs. Goals and objectives are identified and the care plans are regularly reviewed.

REHABILITATION TEAM

There is access to clinical psychology, occupational therapy and social work via referral systems. There is also a speech and language therapist. The consultant psychiatrist visits the unit on a fortnightly basis to review the residents. There is access to a NCHD and an on-call system which was reported as problematic at times. Residents are also registered with a GP. A medical on-call service is provided by the local primary care service CAREDOC.

INVOLVEMENT IN REHABILITATION PROGRAMMES

Residents are involved in a number of activities on the unit including art, music, health and fitness, aromatherapy, massage and have extremely close links with the Special Olympics and are continuing to participate in competitive events organised throughout the country. Also the unit has a very popular arts exhibition.

CLINICAL RISK MANAGEMENT

There was evidence of policies on clinical risk management and individual risk assessments. Any serious incidents were recorded on appropriate forms and sent to management.

UNIT MANAGEMENT

The staff in the residence are all qualified psychiatric nurses and also third year students. The preferred staffing numbers are four staff nurses and a CNM2 during the day plus an activation person from 0900h to 1700h. However, there are often three staff nurses and student nurses with the CNM2 during the day. There are three staff nurses at night. The staff are supplied via a central rostering system although there are core staff who have completed a course that concentrates on a number of obtainable skills for people with intellectual disabilities such as RSA examinations, life and living skills, communication skills, numeracy, IT skills and leisure. There is a formal process of induction for new staff and there are appropriate policies and procedures present. Maintenance can be difficult to obtain at times although the premises were in an excellent condition. Meals are prepared at St. Canice's Hospital and transferred to the unit. Residents' finances are managed for them with supervision from staff. A number of residents visit community facilities close to the unit.

SERVICE USER INVOLVEMENT

Residents are involved as much as possible in their care but due to their intellectual disability are often unable to partake fully. There is a complaints procedure.

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RECORDS

Residents' files were in good condition and were satisfactory. They were signed and dated and contained entries from various personnel. The prescriptions were all signed, dated, legible and used generics.

ENVIRONMENT

There was an ongoing maintenance programme in place provided by St. Canice's Hospital. The hygiene and décor of the residence was excellent. The furniture was comfortable and the units are affording as much safety, privacy and dignity as possible to the residents. The unit was divided into three separate areas with a communal area for activities. Each of the 7-bed areas had a mixture of single rooms and shared bedrooms with a lounge, kitchen, dining room and sufficient toilets and bathrooms.

STAFF TRAINING

Staff receive appropriate training to meet the needs of the residents.

TÚS NUA

Date of inspection: 15th September 2005

Number of beds: 10

DESCRIPTION

Tús Nua is a large two-storey house located very centrally in Kilkenny city. It was a former B&B and only opened as a high support residence in April 2005. It is home to seven residents aged between 37 and 55 years old. Three general adult sectors have admitting rights to the residence.

REFERRAL/ADMISSION PROCESS

All of the current residents were referred to the residence by a consultant psychiatrist. Many came from other residences. At present there are no admission criteria. The focus is on rehabilitation and

the nursing staff are keen that this will be reflected in any admission criteria. All residents are reviewed at set intervals by the medical team in the day hospital. There was an open day prior to the opening for residents and their families.

CARE PLAN

There is no multidisciplinary care plan in place. All residents are registered with local GPs. Nursing staff and residents are in contact with families. There have been no discharges to date.

NURSING PROCESS

The nursing model in use is the Orem Peplau model. This is used in conjunction with the life skills profile. They are currently being introduced for each resident.

REHABILITATION TEAM

There is no rehabilitation team. All residents remain under the sector consultant psychiatrist. Each resident is reviewed in the day hospital clinic. There is one CNM2 rostered each day with a domestic staff member. A staff nurse is rostered by night.

INVOLVEMENT IN REHABILITATION PROGRAMMES

Each resident has an individual programme. Two residents attend open employment with FÁS and one resident is on a FÁS computer course. Three residents attend industrial therapy in the hospital. Other residents work with family and pursue individual hobbies. A number of residents go home to their families' houses at the weekends.

UNIT MANAGEMENT

The residence is managed by nursing staff who are rostered centrally and are currently consistent. The ethos is clearly one of rehabilitation. As it is a new residence, specific policies are in the early stages of development.

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HOUSE RULES

Each resident has signed house rules. Each resident has a front door key and can lock bedroom and bathroom doors. Residents generally let staff know when they are leaving the house. All meals are prepared on site. Each resident is responsible for breakfast. Some residents prepare and cook meals for themselves. All residents have access to the kitchen. There is one double room; all others are single with en-suite facilities. Up to seven residents independently manage their own money. One resident has his money managed by a family member and nursing staff manage money for the other two residents. There is no financial policy in place. The residence is located very centrally. Residents independently access local facilities and attend support group meetings.

SERVICE USER INVOLVEMENT

There is a monthly community/house meeting and minutes are taken of this meeting. Information on medication and other treatment is provided verbally.

RECORDS

The charts reviewed were in order and showed evidence of recent reviews and plans. There was no signature bank available. A number of residents are on a self-medicating programme and this is a goal for the other residents. The card index system was in order.

ENVIRONMENT

This is a large two-storey house with a secluded rear garden. It is a non-smoking house. There were two single bedrooms downstairs. There was one sitting room, kitchen/dining area and a nursing office and laundry room. The house was in good decorative order and residents spoken to were very happy. They particularly valued individual bedrooms for privacy and dignity.

STAFF TRAINING

Staff access in-service training programmes through Carlow/Kilkenny Mental Health Service.

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RECOMMENDATIONS

KILKENNY

ST. CANICE'S HOSPITAL RECOMMENDATIONS

OVERALL RECOMMENDATIONS

1. Preparation must be made for the closure of the hospital by assessing patients for appropriate services.
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.
3. There should be regular multidisciplinary team meetings on each ward.
4. There should be therapeutic needs-based activities available for patients on wards.
5. All written interventions and prescriptions must be dated, have a legible signature with the name and designation of the clinician clearly printed.
6. Each patient should have a regular medical and psychiatric review which should be clearly documented in the clinical file.
7. There should be a restraint policy available on each ward.

ST. LUKE'S WARD

1. Essential maintenance should be carried out as a matter of urgency. Curtains should be provided for the ward.

ST. JOSEPH'S WARD

1. The plan to close this ward should proceed as quickly as possible.

DEPARTMENT OF PSYCHIATRY

1. The unit should be self-staffing.
2. Appropriate signage should be displayed advertising the use of CCTV.

COMMUNITY RESIDENCES

OVERALL RECOMMENDATIONS

1. Each resident should have an integrated care and treatment plan that contains a social, psychological, occupational, nursing, psychiatric and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the resident and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the resident has been involved in developing his or her care plan, and has a copy of the care plan. The care plan must be coordinated by the resident's key worker.
2. There should be a multidisciplinary rehabilitation team in place with responsibility for all 24-hour supervised community residences.

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MOUNT LACKEN

1. The unit requires redecoration.

KINCORA HOSTEL

1. The toilet and shower area require redecoration.

ALTAMOUNT

1. Health professionals should document assessments and interventions in the residents clinical file.

CARLOW**ST. DYMUNA'S HOSPITAL****OVERALL RECOMMENDATIONS**

1. Preparation must be made for the closure of the hospital by assessing patients for appropriate services.
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.
3. There should be regular multidisciplinary team meetings on each ward.
4. There should be a restraint policy on each ward.
5. There should be needs based therapeutic activities on the wards for patients who do not attend activities away from the wards.
6. Essential maintenance should be carried out and a programme of maintenance should be put in place.

ST. ANNE'S WARD

1. All patients should have regular physical and mental status reviews and these should be documented in the clinical files.

COMMUNITY RESIDENCES

1. Each resident should have an integrated care and treatment plan that contains a social, psychological, occupational, nursing, psychiatric and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the 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 resident has been involved in developing his or her care plan, and has a copy of the care plan. The care plan must be coordinated by the resident's key worker.
2. There should be a multidisciplinary rehabilitation team in place with responsibility for all 24 hour supervised community residences.

PARK LODGE

1. The residence requires redecorating.

BEECHWOOD

1. All medication prescriptions should be up to date.

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SOUTH TIPPERARY

ST. LUKE'S HOSPITAL, CLONMEL

OVERALL RECOMMENDATIONS

1. Direct admissions and transfers from the admission unit must cease.
2. Each patient must 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.
3. There should be a multidisciplinary rehabilitation team with responsibility for patients in long-stay wards.
4. There should be regular multidisciplinary team meetings on each ward.
5. There should be needs-based therapeutic activities on the wards for patients who do not attend activities away from the wards.
6. There are a number of patient groups requiring different types of care on the same ward. Each patient should be assessed regarding their accommodation needs and appropriate accommodation should be found.
7. Essential maintenance should be carried out throughout the hospital as a matter of urgency.
8. All written interventions and prescriptions must be dated, have a legible signature with the name and designation of the clinician clearly printed.

ADMISSION UNIT: ST. MICHAEL'S UNIT

1. There should be adequate signage that CCTV is in use in the unit.

ST. TERESA'S WARD

1. Each patient should be assessed regarding their accommodation needs and appropriate accommodation should be found.

ST. BRIDGET'S WARD

1. The practice of patients using the seclusion room as a bedroom should cease.

ST. JOHN'S WARD

1. The seclusion room is not suitable for the seclusion of patients. It should be brought to an acceptable standard or closed.

ST. PAUL'S WARD

1. Discontinuation of medication must always be signed.

ST. CLAIRE'S WARD

1. Adequate showering and bathing facilities for patients should be put in place

COMMUNITY RESIDENCE

RESIDENCE HOUSE

1. Each resident should have an integrated care and treatment plan that contains a social, psychological, occupational, nursing, psychiatric and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the resident and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the resident has been involved in developing his or her care plan, and has a copy of the care plan. The care plan must be coordinated by the resident's key worker.
2. There should be a multidisciplinary rehabilitation team in place with responsibility for all 24-hour supervised residences.

WATERFORD

OVERALL RECOMMENDATIONS

1. The future role of St. Otteran's Hospital must be decided and all admissions and transfers to long-stay wards should cease.
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.
3. There should be regular multidisciplinary team meetings on each ward.
4. Each unit and ward should be self-staffing.
5. Each patient should have access to an advocacy service.

DEPARTMENT OF PSYCHIATRY WATERFORD REGIONAL HOSPITAL

1. Transfer of patients to long-stay wards should cease.
2. Nursing patients in night clothes should be as part of an individual care plan and not routine on admission.

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ST. OTTERAN'S HOSPITAL

ST. JOSEPH'S WARD

1. All written interventions and prescriptions must be dated and have a legible signature with the name and designation of the clinician clearly printed.
2. Each bed must have curtains to offer privacy and dignity to the patient.

ST. ENDA'S WARD

1. The nursing care plans should be up to date.
2. Safety deficiencies in the seclusion room should be addressed.
3. Patients' concerns about the quality of food should be addressed.
4. As this ward is unsuitable for patients it should close as a matter of urgency and the patients placed in appropriate accommodation.

ST. CLAIRE'S WARD

1. The function of this ward needs to be determined. If it is to provide a rehabilitation service then a full multidisciplinary rehabilitation team must be responsible for the ward. All long-stay patients should be assessed for more appropriate accommodation.
2. All patients should have access to a needs-based activity programme based on care plans.

ST MONICA'S WARD

1. The nursing models in use should be regularly reviewed to ensure that the assessed needs of the patient are being met.
2. There should be funding to ensure that the patients receive the appropriate assessment and treatment of their dietary needs.

COMMUNITY RESIDENCES

OVERALL RECOMMENDATIONS

1. Each resident should have an integrated care and treatment plan that contains a social, psychological, occupational, nursing, psychiatric and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the resident and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the resident has been involved in developing his or her care plan, and has a copy of the care plan. The care plan must be coordinated by the resident's key worker.
2. There should be a multidisciplinary rehabilitation team in place with responsibility for all 24-hour supervised community residences.

ACTIVATION UNIT

1. The activation unit requires redecorating and essential maintenance.
2. There should be input from an occupational therapist to the activation unit.

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WEXFORD

ST. SENAN'S HOSPITAL

OVERALL RECOMMENDATIONS

1. Each patient should have an integrated care and treatment plan that contains a social, psychological, occupational, nursing, psychiatric and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the patient and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the patient has been involved in developing his or her care plan, and the patient must have a copy of the care plan. The care plan must be coordinated by the patient's key worker.
2. There should be regular multidisciplinary team meetings on each ward.
3. The practice of patients sleeping in long-stay wards due to bed shortages elsewhere in the service should cease.
4. There should be therapeutic needs based activities available for patients on wards.
5. There should be a structure in place for obtaining patients' and carers' views and feedback about the service.
6. All written interventions and prescriptions must be dated, have a legible signature with the name and designation of the clinician clearly printed.
7. The nursing models in use should be regularly reviewed to ensure that the assessed needs of the patient are being met.
8. All units should be self-staffing to ensure continuity of care.

ADMISSION WARDS: ST CLAIRE'S WARD (MALE) AND ST. ANNE'S WARD (FEMALE)

1. Children under 16 years of age should not be admitted to these wards.
2. There should be no admissions solely for detoxification.
3. There should be a policy regarding locking external doors to the unit.
4. There should be a ward clerk available to the wards.
5. There should be a bed management policy in place.
6. There should be a high observation area in the admission ward.
7. Urgent maintenance should be carried out on the wards immediately and a programme of maintenance put in place.
8. The issue of confidentiality in relation to the nursing office in the male admission ward should be urgently addressed.
9. Worn curtains and bed covers should be replaced.

ST AIDAN'S WARD

1. Procedures should be put in place to ensure that patients can access medical and surgical appointments as necessary.
2. The shower room should be renovated.
3. There should be an information technology system installed.

ST. CHRISTOPHER'S WARD

1. Staff should be trained in sign language appropriate for people with intellectual disability.
2. Patients must have regular physical and mental state examinations and these should be recorded in the patients' clinical file.

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3. Due to the unacceptable conditions in the ward, the ward should be closed and the patients moved to a more suitable location as a matter of urgency.

ST. FIDELMA'S WARD

1. There should be a policy on the use of restraint.
2. Patients must have physical and mental state examinations at least every six months and these should be recorded in the patients' clinical file.
3. There should be availability of thermostatically controlled hot water to all sinks, for the purpose of adequate hygiene.

ST. BRENDAN'S WARD

1. Urgent maintenance should be carried out in the toilet area.
2. Each patient should be assessed for their future accommodation needs.

ST GERTRUDE'S WARD

1. The unit requires a new dishwasher and food trolley.

ST. BRIDGET'S WARD

1. All patients should have access to an independent advocacy service.
2. Additional showering facilities are required for patients.

ST. ELIZABETH'S WARD

1. All patients should be reviewed regularly by their consultant psychiatrist and this review documented in the clinical file.
2. There should be an information technology system in the ward.
3. There should be essential maintenance carried out on the ward.
4. Essential household items for the ward should be provided.

ST. ENDA'S WARD

1. There should be a policy on restraint.
2. Alternative appropriate accommodation should be available for patients who have completed the rehabilitation programme and are ready for lower levels of supervision.
3. Urgent maintenance should be carried out on the toilet and bathrooms areas.

COMMUNITY RESIDENCES

OVERALL RECOMMENDATIONS

1. Each resident should have an integrated care and treatment plan that contains a social, psychological, occupational, nursing, psychiatric and medical needs assessment, including a risk assessment, a documented set of goals collaboratively developed by the resident and the multidisciplinary team, and interventions by appropriate members of the multidisciplinary team, with regular formal multidisciplinary reviews of the care plan. There must be documented evidence that the resident has been involved in developing his or her care plan, and has a copy of the care plan. The care plan must be coordinated by the resident's key worker.
2. There should be a multidisciplinary rehabilitation team in place with responsibility for all 24-hour supervised community residences.

ARDMINE HOSTEL

1. Residents should be able to lock their own bedrooms and the bathrooms.
2. Each resident should have an assessment of accommodation needs.

58 WESTLANDS

1. The number of residents in the hostel should be reduced to prevent overcrowding.

