EXECUTIVE CATCHMENT AREA	Dublin North Central/North West Dublin
HSE AREA	Dublin North East
MENTAL HEALTH SERVICE	North West Dublin
APPROVED CENTRE	St. Brendan's Hospital
NUMBER OF WARDS	Four
NAMES OF UNITS OR WARDS INSPECTED	Unit O
TOTAL NUMBER OF BEDS	57
CONDITIONS ATTACHED TO REGISTRATION	Yes
TYPE OF INSPECTION	Unannounced Re-inspection
DATE OF INSPECTION	20 December 2011

Reason for Re-inspection

Correspondence of the 8 December 2011, from Dr. Rita Hughes, Clinical Director, St. Brendan's Hospital, to the CEO of the Mental Health Commission had advised that five female residents were to be temporarily transferred from Ward 3B to Unit O in the approved centre owing to a shortage of nursing staff. Ward 3B provided rehabilitation services and open access for residents who resided there. Unit O provided care and treatment to residents in a low secure setting with locked doors. Following the transfer of the residents from Ward 3B, there were 12 residents in Unit O, two of whom were involuntarily detained. It was originally indicated that this arrangement would be in place until the 16 January 2012 but the Inspectorate was informed on the day of inspection that the residents would be moved back to Ward 3B on the 2 January 2012. In addition, there had been media coverage of the transfers and some suggestion that families of the residents concerned were unhappy with the move.

The purpose of this unannounced re-inspection was to verify the issues surrounding the transfer of the residents and specifically how this impacted on their wellbeing. The Inspectors visited Unit O and examined the facilities, met with staff and residents and examined individual clinical files.

Decision to transfer

Senior management at the hospital had taken the decision to close Ward 3B because of a shortage of nursing staff to cover the Christmas period. Staff reported that 40 nursing posts had been lost in the catchment area since September 2011. This combined with the recruitment freeze meant that there would be insufficient staff available over the holiday period to cover all wards.

Inspection of the clinical files of those residents transferred indicated that they were informed of the impending move on the 7 December 2011, four or five days prior to the transfer. Although Unit O was a locked ward, all five residents from Ward 3B were at liberty to leave the ward at any time, although in fact only two residents availed of this because of medical difficulties. The staff of Unit O was well known to the 3B residents because staff worked across units in the approved centre.

Staff reported that consideration had been given to the temporary closing of Unit O and moving those residents to Ward 3B, however, the physical layout of 3B was unsuited to all residents' needs and there was no direct access to a garden on that unit. The option of transferring residents to other approved centres was also rejected as it was considered too much of an upheaval for the particular residents concerned. Indeed, one resident was offered the choice of a bed in another facility and declined.

Conditions on Unit 0

Prior to the transfer of the residents from Unit 3B, Unit O provided care for seven residents in a locked ward. The ward had one sitting room, one dining room, two showers (one of which was part of the seclusion suite), five lavatories, one large dormitory with ten beds and two small single bedrooms off the main dormitory. Each bed had a curtain around it for privacy. There was access to a garden which was situated adjacent to the ward. On the morning of inspection, the occupational therapist (OT) provided an activity session within Unit O and therapeutic activities were also provided in the OT department and the activity centre. One of the transferred residents had been out on their own shopping nearby.

Interview with nursing staff and treating consultant

Nursing staff on Unit O and one of the treating consultant psychiatrists stated that they were informed by senior management on the 2 December 2011 about the intention to close Ward 3B as an interim measure

owing to a shortage of nursing staff. Medical staff expressed concern at the impact of additional residents on the residents already in Unit O.

Interview with residents

The inspectors met with two of the residents who had been transferred; the other three residents were attending therapy in the therapy unit at the time of inspection.

Individual clinical file review

The clinical file of each resident transferred was inspected. It was clear from the files that the only purpose of the transfer was to accommodate a staff shortage. It was evident that the treating consultant had paid particular attention to individual discussion with each resident about the move and the resident's response, wellbeing and concerns in relation to this. Their care had been managed in an individualised way. Clinical files indicated that residents had been regularly reviewed by the treating team since moving to Unit O.

Conclusions

Although the inspectors were satisfied that the residents who had been transferred from Ward 3B were being well cared for in Unit O, it was a very unsatisfactory arrangement for both these residents and for the residents of Unit O. The transfer of five residents had resulted in Unit O being at full capacity and residents whose needs ranged from high dependency acute care to rehabilitation were mixed together and being cared for in an already cramped setting. The decision to transfer residents within the approved centre was contrary to the Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre, where transfer includes a resident's move and transfer of care within an approved centre and which in this case could not be said to be "in the best interests of the resident" (S25.1), but merely an arrangement to meet a staff shortage.

Recommendations

It is recommended that residents should not be transferred to alleviate a staff shortage.