



**REPORT OF THE**

**COMMITTEE OF INQUIRY INTO**

**CURRENT CARE AND TREATMENT**

**PRACTICES**

**IN THE CENTRAL MENTAL**

**HOSPITAL**

**2006**



# **MENTAL HEALTH COMMISSION**

## **RESPONSE TO INQUIRY REPORT**

**January 2007**

## **Mental Health Commission response to Inquiry Report on Current Care and Treatment Practices in the Central Mental Hospital**

The Mental Health Commission, an independent statutory body, was established in April 2002 under the provisions of the Mental Health Act, 2001. The overarching mandate of the Commission, as per section 33(1) of the Mental Health Act, 2001 is as follows:-

“The principal functions of the Commission shall be to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres under this Act.”

In April 2005, the Mental Health Commission decided to establish an Inquiry as per section 55, Mental Health Act, 2001<sup>1</sup>, to review current care and treatment practices in the Central Mental Hospital, Dundrum and to report to the Commission.

The following were appointed by the Mental Health Commission to complete the Inquiry:-

Dr. Janet Parrott, Consultant Forensic Psychiatrist and Clinical Director in Forensic Mental Health Services, Oxleas NHS Trust, and Chair of Committee.

Dr. Teresa Carey, Consultant Psychiatrist and Inspector of Mental Health Services (Dr. Carey ceased to be a member of the Inquiry Committee on 27<sup>th</sup> March 2006).

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<sup>1</sup> “55 (1) The Commission may, and shall if so requested by the Minister, cause the Inspector or such other person as may be specified by the Commission, to inquire into -

- (a) the carrying on of any approved centre or other premises in the State where mental health services are provided,
- (b) the care and treatment provided to a specified patient or a specified voluntary patient by the Commission,
- (c) any other matter in respect of which an inquiry is appropriate having regard to the provision of this Act or any regulations or rules made thereunder or any other enactment.

(2) Where a person carries out an inquiry under this section, he or she shall, as soon as may be, prepare a report in writing of the results of the inquiry and shall submit the report to the Commission.

(3) A report under *subsection (2)* shall be absolutely privileged wherever and however published.”

Dr. Susan Finnerty, Consultant Psychiatrist and Assistant Inspector of Mental Health Services.

Mr. Des McMorrow, Assistant Inspector of Mental Health Services.

Dr. Douglas MacInnes, Reader in Mental Health, Canterbury, Christ Church University.

The report of the Inquiry was completed in November 2006 and was considered by the Mental Health Commission at meetings held on 7<sup>th</sup> December 2006 and 14<sup>th</sup> December 2006. The Commission endorses the recommendations of the Inquiry Report.

There are a number of practices in the Central Mental Hospital, highlighted in the Inquiry, which infringe on patients' rights and dignity and impact on the standard of clinical care available to them. While it is acknowledged that some of the areas of concern have been addressed, the Inquiry highlights a number of ongoing concerns. Chief among the issues of concern are the following:-

- (i) Use of Seclusion
  - Its apparent over-use on some wards
  - The failure to ensure that it is used only as a last resort
  - The lack of appropriate clinical audit of every episode of seclusion
  - The method in which seclusion is implemented on the female ward
  - The use of seclusion for new patients on the admission wards
- (ii) The blanket policy of locking patients in their rooms all night (except in the hostel), irrespective of level of risk.
- (iii) Patients are often kept waiting in a locked bedroom when needing to use the toilet since "slopping out" has ceased.
- (iv) All patients in certain units must go out for cigarette breaks irrespective of whether they smoke or not.
- (v) Restrictions on access to the grounds due to staffing levels and apparently independent of the level of risk.
- (vi) Central rostering, resulting in
  - Lack of continuity of ward staff
  - Barrier to developing therapeutic relationships with patients
  - Impossibility of implementing a "key nursing" system
  - Failure to involve ward staff in MDT<sup>2</sup> risk assessment, care planning, care implementation and care review.

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<sup>2</sup> Multidisciplinary team.

(vii) Absence of clear clinical leadership in wards resulting in:

- No clear line of accountability for standards of care in each ward
- Lack of implementation of policies, including policies on risk assessment, risk management and seclusion
- Absence of “key nursing system”
- Lack of involvement of ward staff in MDT working
- Lack of patient involvement in their care planning
- Patients frequently missing off-ward therapeutic sessions due to lack of ward organisation

It is accepted that there are longstanding organisational issues underpinning these unacceptable practices in the Central Mental Hospital. It is also accepted that the buildings are old and not in keeping with the delivery of a modern service. To ensure the provision of a quality mental health service regime within the Central Mental Hospital the following actions must be undertaken:-

The HSE must take clear and transparent responsibility for

- Funding the service
- The provision of adequate staffing, including removing the cap on recruitment, if necessary
- Dealing with high-level industrial relations issues affecting standards of clinical care
- Development of an appropriate forensic service for women
- Implementing the recommendations in “Vision for Change” dealing with the development of a national forensic mental health service.

The Local Management Team must take clear responsibility for standards of care delivered to patients. This will be greatly facilitated by:-

- Including psychology, social work and occupational therapy personnel as full members of the Senior Management Team.
- Abolishing the system of central rostering of nursing and care officer staff and moving to a system of individual or “grouped wards” staffing, with each staffing “unit” being responsible for managing staffing rosters.
- Having a regular forum where the SMT meet formally with relevant senior staff involved in service delivery, including senior ward staff, industrial therapy staff, vocational training staff, horticulture staff, catering staff and any other relevant staff.
- The immediate appointment of senior nursing staff as unit manager in all wards, with responsibilities which include the implementation of clinical care policies and the maintenance of high clinical care standards.

- The immediate implementation of the key nursing system, with the key nurse of each patient attending all MDT assessment, care planning and care review meetings on their patients.
- The abolition of the system whereby all MDTs may have patients on all wards. While it may be appropriate to continue to have such a system in place for short-stay patients, an individual consultant and associated MDT should take responsibility for specific wards. This would have multiple advantages, including incorporating ward staff into the MDT and introducing clear accountability for clinical care standards.

There should be a clear requirement to audit all episodes of seclusion and to ensure that risk assessment care plans are implemented appropriately, so that no patient is cared for in a way that places excessive restrictions on their freedom. In particular the use of seclusion on the women's unit needs to be reviewed and the recommendations of the Inquiry Report implemented immediately. (The Mental Health Commission has issued rules on the use of seclusion which became operative on the 1<sup>st</sup> November 2006).

The nature and degree of service deficiencies outlined in the Inquiry Report are such that urgent reform of the forensic mental health services based at the Central Mental Hospital is required. The Mental Health Commission is aware that previous reports and recommended reforms of services at the Central Mental Hospital have resulted in only slow and limited service improvements.

The Mental Health Commission will be insisting on an agreed detailed and timed action plan for the implementation of the service reforms recommended in this Report. The Commission through the Inspectorate of Mental Health Services will monitor the rollout of this plan.

Dr. John Owens  
**Chairman  
Officer  
Mental Health Commission  
Commission**

Brid Clarke  
**Chief Executive  
  
Mental Health**

10<sup>th</sup> January 2007

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## SECTION 1 - INTRODUCTION

### ESTABLISHMENT OF THE INQUIRY

The Mental Health Commission was established in April 2002 as an independent statutory body under the provisions of the Mental Health Act 2001. The overall statutory duties of the Commission are laid out in Section 33(1) of the Act:-

*“33(1) The principal functions of the Commission shall be to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres under this Act.”*

In pursuance of these duties the Commission decided at its meeting on 29th April 2005 to establish an Inquiry Committee, under Section 55 of the Mental Health Act 2001, to review current care and treatment practices in the Central Mental Hospital (C.M.H.) and to report to the Commission. Section 55 of the Act empowers the Mental Health Commission to establish an Inquiry into a named centre where mental health services are provided or into the care and treatment of a specific service user.

The Mental Health Commission had drawn attention to areas of concern in working practices and the environment at the C.M.H. in its inspection of 30<sup>th</sup> November 2004 (published in the annual report of the Inspector of Mental Health Services, July 2005). The Commission were also mindful of the death of a service user in the C.M.H. on the 12<sup>th</sup> September 2001 and that a member of staff was being prosecuted in relation to this incident. The Inquiry Committee were advised that the Inquiry's terms of reference did not include a review of this case but that the Commission sought to implement a more detailed Inquiry into working practices at the hospital than could be accommodated within the more limited remit of the annual inspection process.

The following were notified by letter and in confidence of the planned Inquiry on the 26<sup>th</sup> May 2005:

Mr. Kevin Kelly, Acting Chief Executive, Health Service Executive;

Mr. Aidan Browne, National Director, P.C.C.C., Health Service Executive;

Mr. Donal Devitt, Assistant Secretary, Department of Health and Children

Dr. Harry Kennedy, Clinical Director, C.M.H.

### **MEMBERSHIP OF THE COMMITTEE OF INQUIRY**

The Inquiry was conducted by a Committee comprising three members of the Inspectorate of Mental Health Services and two external members as follows:

Dr. Teresa Carey                      Consultant Psychiatrist and Inspector of Mental Health Services

(Dr. Carey ceased to be a member of the Inquiry Committee on 27<sup>th</sup> March 2006.)

Dr. Susan Finnerty                      Consultant Psychiatrist and Assistant Inspector of Mental Health Services

Mr. Des McMorrow                      Assistant Inspector of Mental Health Services

Dr. Janet Parrott                      Consultant Forensic Psychiatrist and Clinical Director in Forensic Mental Health Services, Oxleas NHS Trust

Dr. Douglas MacInnes                      Reader in Mental Health, Canterbury, Christ Church University

The Commission considered it appropriate to balance the requirement for the Inquiry Committee to have an extensive knowledge base of national mental health services with a degree of independence from the Commission. Liaison with the National Director for Mental Health at the Department of Health in the U.K. led to Dr. Janet Parrott being asked to chair the Inquiry Committee. The Inquiry Committee's resources in the areas of forensic nursing practice and user experience were further enhanced by the appointment of Dr. MacInnes which provided a similarly independent aspect to the work. Dr. Susan Finnerty has previous experience of Inquiries in mental health services and Mr. Des McMorrow has experience in the management of forensic mental health services and in nursing practice which complemented their wide experience on the Inspectorate.

The appointment of Dr. Parrott and Dr. MacInnes was approved by the Mental Health Commission at its meeting on the 28<sup>th</sup> July 2005. Both Dr. Parrott and Dr. MacInnes were appointed as Assistant Inspectors of Mental Health Services for the purpose and duration of the Inquiry as required by the legislative provisions of the Mental Health Act 2001.

Legal advice to the Commission in relation to the Inquiry was provided by Arthur Cox. Ms. Colette Ryan, Mental Health Commission provided administrative support.

### **TERMS OF REFERENCE**

The Terms of Reference initially set down by the Mental Health Commission for the Inquiry Committee were:

*“To review current care and treatment practices in the C.M.H.”*

It was made clear that the Inquiry Committee had not been asked to investigate any specific incidents or allegations. Following the first meeting of the Inquiry Committee on the 23<sup>rd</sup> September 2005 a request was made for clarification of these terms of reference particularly in respect of the time period to be included in the review. The Mental Health Commission responded as follows:

*“The concerns of the Mental Health Commission are informed by the Inspector of Mental Health Services’ 2004 report on the facility and the perceived custodial emphasis within the C.M.H.. In relation to the time period for review, the Mental Health Commission agreed that the review should cover the period commencing the 1<sup>st</sup> January 2004”.*

The Inquiry Committee notes that the service provided at the C.M.H. forms part of the wider provision of the National Forensic Psychiatry Service but the Inquiry necessarily focuses on care and treatment within the C.M.H. itself as per the Terms of Reference.

**LEGAL POWERS AND AUTHORITY OF INQUIRY COMMITTEE**

Section 51 (2) of the Mental Health Act, 2001 refers to the powers of the Inspector (and Assistant Inspectors see Section 54 (2) and (3)) in the performance of her duties under the Act. Section 51 (2), (3) and (4) is as follows:

*“51 (2) – The Inspector shall have all such powers as are necessary or expedient for the performance of his or her functions under this Act including but without prejudice to the generality of the foregoing, the following powers:*

- a) *to visit and inspect at any time any approved centre or other premises where mental health services are being provided and to be accompanied on such visit by such consultants or advisers as he or she may consider necessary or expedient for the performance of his or her functions,*
- b) *to require any person in such an approved centre or other premises to furnish him or her with such information in possession of the person as he or she may reasonably require for the purposes of his or her functions and to make available to the Inspector any record or other document in his or her power or control that in the opinion of the Inspector, is relevant to his or her function,*
- c) *to examine and take copies of, or of extracts from, any record or other document made available to him or her as aforesaid or found on the premises,*
- d) *to require any person who, in the opinion of the Inspector, is in possession of information, or has a record in his or her power or control, that, in the opinion of the Inspector, is relevant to the purposes aforesaid to furnish to the Inspector any such information or record and, where appropriate, require the person to attend before him or her for that purpose,*
- e) *to examine and take copies in any form of, or of extracts from any record that, in the opinion of the Inspector, is relevant to the review or investigation and for those purposes take possession of any such record, remove it from the premises and retain it in his or her possession for a reasonable period, and*
- f) *to take evidence on oath and for that purpose to administer oaths.*

*(3) – Subject to subsection (4), no enactment or rule of law prohibiting or restricting the disclosure or communication or information shall preclude a person from furnishing to the Inspector any such information or record, as aforesaid.*

*(4) – A person to whom a requirement is addressed under this section shall be entitled to the same immunities and privileges as a witness in a court”*

Section 55 (3) – states that a report of an Inquiry established under Section 55 “*shall be absolutely privileged wherever and however published*”.

## **SECTION 2 - COURSE AND CONDUCT OF THE INQUIRY**

### **DATES OF COMMITTEE MEETINGS**

A preliminary planning meeting of the Inquiry Committee took place on 16<sup>th</sup> August 2005 and Dr. Parrott and Dr. MacInnes made a familiarisation visit to the C.M.H. on 24<sup>th</sup> and 25<sup>th</sup> August 2005 which included visiting Usher's Island and Cloverhill and Wheatfield prisons. Those members of the Inquiry Committee who had not previously visited a medium secure forensic service in the U.K. made a familiarisation visit to the Bracton Centre, Oxleas NHS Trust on 6<sup>th</sup> December 2005. The first formal meeting of the Inquiry Committee occurred on 23<sup>rd</sup> September 2005 and further meetings occurred on 6<sup>th</sup> December 2005, 4<sup>th</sup> and 6<sup>th</sup> January, 27<sup>th</sup> March, 20<sup>th</sup> April, 29<sup>th</sup> May, 11<sup>th</sup> July and 31<sup>st</sup> July 2006.

### **CONSULTATION ON DRAFT REPORT**

The draft report was made available for consultation to stakeholders and comments were considered and incorporated into the final report when the Inquiry Committee considered this appropriate. The following groups were specifically given the opportunity to comment: Senior Management Team, heads of discipline, all consultants and other senior staff and representatives of three unions (Psychiatric Nurses Union, Services Industrial Professional and Technical Union and Irish Municipal Public and Civil Trade Union). The section on Carers was made available to the carer's groups. The Irish Advocacy Network undertook to consult with service users on the draft report as far as practicable and collate feedback.

### **PROCESS AND RATIONALE**

The Inquiry Committee initially focussed on how best to secure a process of Inquiry that was robust in its review of working practices at the C.M.H. but engaged staff across all disciplines and avoided the alienation and sapping of staff morale that can accompany processes of Inquiry.

The Commission was entirely supportive of these concerns and legal advice was sought in support of a process that aimed to work with staff, users, carers and voluntary organisations in identifying strengths and weaknesses of working practices

at the C.M.H. and making a more detailed review of any areas of particular concern. An approach was developed that built on the regular process of inspection by the Inspectorate and was informed by the reviews of mental health practice in the U.K. utilised by the Health Care Commission.

It was agreed that the Inquiry would implement a process based on the voluntary participation of staff, users and carers at all levels of the organisation and utilise the usual approach of the Inspectorate (underpinned by their statutory powers) with regard to interviewing service users, access to service user records, policies and reviews of clinical practice. There is precedent for an Inquiry to develop a two stage procedure where there is an option of entering a formal second phase if the first phase of information gathering indicates that an adverse conclusion might be drawn in relation to certain individuals dependant on the testimony of others. The Inquiry Committee's understanding of this matter in the context of an examination of working practices in a health facility was that an enhanced form of inspection could form such a first phase and that the Inquiry Committee would not expect to utilise their formal powers under Section 52 of the Mental Health, Act 2001 in relation to individuals during this phase.

It was decided that should an allegation of a serious nature be made in the course of this process this information would be passed to the Commission. A decision would then be taken as to whether such an allegation could be investigated by the C.M.H. or if a formal second phase of the Inquiry would be implemented where individuals at risk of an adverse finding against them would be entitled to attend, hear the evidence and cross examine witnesses. The Inquiry Committee did not consider comments or potential criticisms about the organisation or parts of the organisation to require a formal approach to evidence gathering given that the review would use a triangulation process whereby information is checked with other sources and in the context that external review with a view to identifying and addressing any areas of concern is a usual component of Clinical Governance. The Inquiry Committee did not find it necessary to commence a formal second phase of Inquiry.

## **BRIEFING OF RELEVANT GROUPS**

Letters advising of the Inquiry, terms of reference and dates of meetings were sent to all members of staff and service users at the C.M.H. Letters were also sent to relatives or friends of service users known to the Social Work Department. Copies of these letters are provided in Appendix (1). The Inquiry Committee was advised of advocacy and carers' groups working with the C.M.H. and requested their involvement.

The Inquiry Committee met representatives of the three main unions who represent nursing and care staff at the C.M.H. i.e. the (P.N.A.), (S.I.P.T.U.) and (IMPACT) on the 24th February 2006. The proposed methodology to review working practices was considered satisfactory by these representatives and the Inquiry Committee was assured that the unions supported the engagement of their members in the process recognising that it remained an individual decision as to whether members of staff participated.

The Inquiry Committee held a meeting with the Senior Management Team and Heads of other disciplines at the C.M.H. on 27<sup>th</sup> March 2006 to explain the process of the Inquiry and receive comments as how best to work with staff to secure maximum engagement in the interests of robust review and of improving the quality of care in the longer-term. This group requested an entitlement to make comments on the final draft of the report and this was agreed.

## **REVIEW OF POLICIES AND RELEVANT DOCUMENTATION**

The Inquiry Committee initially identified core areas for investigation in relation to its Terms of Reference and arising from the 2004 Inspectorate report as follows:

- The Care Process
- Multidisciplinary Team Function
- Serious Incident Reviews including Risk Management
- Seclusion and Restraint
- Service User and Family Involvement
- Training and Continuing Professional Development



The Inquiry Committee requested information and copies of policies and procedures from the C.M.H. and reviewed documentation provided (details available in Appendix (2)). The Senior Management Team was asked to provide additional information relating to the following areas:

1. Strategic Priorities for the C.M.H.
2. Organisational Arrangements for Clinical Governance
3. Information used Routinely to Monitor Quality of Care
4. Clinical Effectiveness
5. Staffing and Staff Management

The Inquiry Committee is grateful for the work done by senior staff at the C.M.H. in providing this information.

### **INTERVIEWS CONDUCTED BY THE INQUIRY COMMITTEE**

(27<sup>th</sup> – 30<sup>th</sup> March 2006 and 19<sup>th</sup>, 20<sup>th</sup> and 21<sup>st</sup> April 2006)

#### **Meeting with Senior Management and Heads of Discipline**

The Inquiry Committee arranged meetings with the Clinical Director, Director of Nursing, Acting General Manager, Heads of Social Work, Clinical Psychology and Occupational Therapy. The content of these meetings was recorded in a written memorandum.

#### **Meetings with Other Staff Groups, Carers Groups & Advocacy Networks**

The Inquiry Committee met with each of the following groups: Consultants, non-consultant medical staff, Assistant Directors of Nursing and Superintendent Care Officers, Occupational Therapists, Psychologists, Social Workers and Principal Care Officers. It was clear that the majority if not all of the staff available at the time of these meetings had prioritised their attendance. Meetings with the community nursing team, Vocational Officers, the Catering Officer and with staff from the Training Department at the C.M.H. were conducted on the 12<sup>th</sup> May 2006.

#### **Meetings with Unit Based Staff**

The Inquiry Committee met with staff who wished to participate and were available on each unit at the C.M.H.. Two members of the Inquiry Committee met with each

group but alternated in meeting either the staff or service user group for that unit. The Inquiry Committee also took the opportunity to see the unit facilities on each occasion. Visiting dates were co-ordinated such that visits included times when the alternate shift (nursing/care officer) was in operation. The Inquiry Committee considered there to be a good response in terms of participation in these meetings across all units.

In addition to the meetings programme, staff, service users and carers were invited to make written submissions to the Inquiry Committee. All staff were also informed of the option to meet the Inquiry Committee in confidence. A confidential telephone line was set up at the Mental Health Commission and meetings were arranged at St. Martin's House and a nearby hotel to facilitate this option.

#### **REVIEW OF CLINICAL DOCUMENTATION**

Two sets of clinical notes were requested from each ward at the time of the visits between 27<sup>th</sup> and 30<sup>th</sup> March 2006. These were perused to review the quality of the care planning and Therapeutic Care Plan (T.C.P.) documentation. On the 20<sup>th</sup> April 2006 the Inquiry Committee reviewed the notes of any service users secluded on that date or the last two service users to have been secluded on each unit. These requests were promptly facilitated.

#### **USER AND CARER VIEWS**

Two members of the Inquiry Committee met with each service user group on all the wards. The manner of engagement was based on the usual practice of the Mental Health Inspectorate. In addition to this discussion users who were agreeable completed a satisfaction questionnaire, the Forensic Satisfaction Scale (MacInnes et al 2006) which was completed during the meeting and did not identify individual service users. There was wide active participation in both the user forums and in completing the satisfaction scale. Further details of the scale can be found in Appendix (3).

The Social Work Department at the C.M.H. facilitated the Inquiry Committee meeting with relatives and friends of service users on the 28<sup>th</sup> March 2006 at the C.M.H. and on the 19<sup>th</sup> April 2006 at the Mental Health Commission offices in St.

Martin's House. The Inquiry Committee met with representatives of Schizophrenia Ireland on 29<sup>th</sup> March 2006.

**H.S.E. MANAGEMENT AND HUMAN RESOURCES**

Meetings occurred with Mr. John Broe, Employee Relations Manager, HSE Dublin – Mid-Leinster (East Coast Area), Mr. Declan Hynes, Corporate Learning and Development Manager and Mr. Brendan Baker, Organisation Design and Development Unit, H.S.E. on 21<sup>st</sup> April 2006 and with Mr. Jim Breslin, Assistant National Director, HSE Dublin Mid Leinster and Mr. Jim Ryan, Local Health Manger, Dublin South on the 12<sup>th</sup> of May 2006 in order to further the Inquiry Committee's understanding of organisational issues.

## SECTION 3 - DESCRIPTION OF SERVICE

### ORGANISATIONAL STRUCTURE

The organisational structure at the C.M.H. is illustrated overleaf. Lines of accountability refer to operational management for senior staff with professional management being provided by the relevant professional manager within the H.S.E. area. In the process of reviewing working practices the Inquiry Committee was not in a position to review organisational issues in detail but focussed on clinical governance structures and enquired about specific factors such as working relationships and industrial relations where these were felt to have an impact on service user care. At the present time the Central Mental Hospital in Dundrum provides a national forensic service. As there are no other forensic facilities in the state, the hospital provides high, medium and low secure accommodation. It also provides an in-reach service to most prisons in the state. This consists of regular clinics in Arbour Hill, Mountjoy, Wheatfield and Portlaoise prison.

The Central Mental Hospital was completed in 1850 following an Act of 1845. It remains more or less unchanged since it was built. Plans are ongoing to build a new forensic hospital at an alternative location.

There are currently 74 (5 not operational) male beds and 7 female beds in the hospital. It has two admission wards, (Unit A and B) which are located in a single storey building on the grounds. There are two medium secure wards, (Units 2 & 3), one special behaviour unit (Unit 4), one low secure ward (Unit 7), in the main building and one hostel in the grounds of the hospital. The women's service is provided in one unit (Unit A) which caters for both short and long stay patients and has a uniform level of high security independent of individual assessed risk.

Within the hospital complex there is a gardening project, industrial therapy, and a Vocational Educational Programme. These programmes are run by vocational staff. There is also a swimming pool and a gymnasium.

There are five consultant led teams and the service is actively recruiting for multidisciplinary team members. Currently there are 6 social workers, 5 occupational

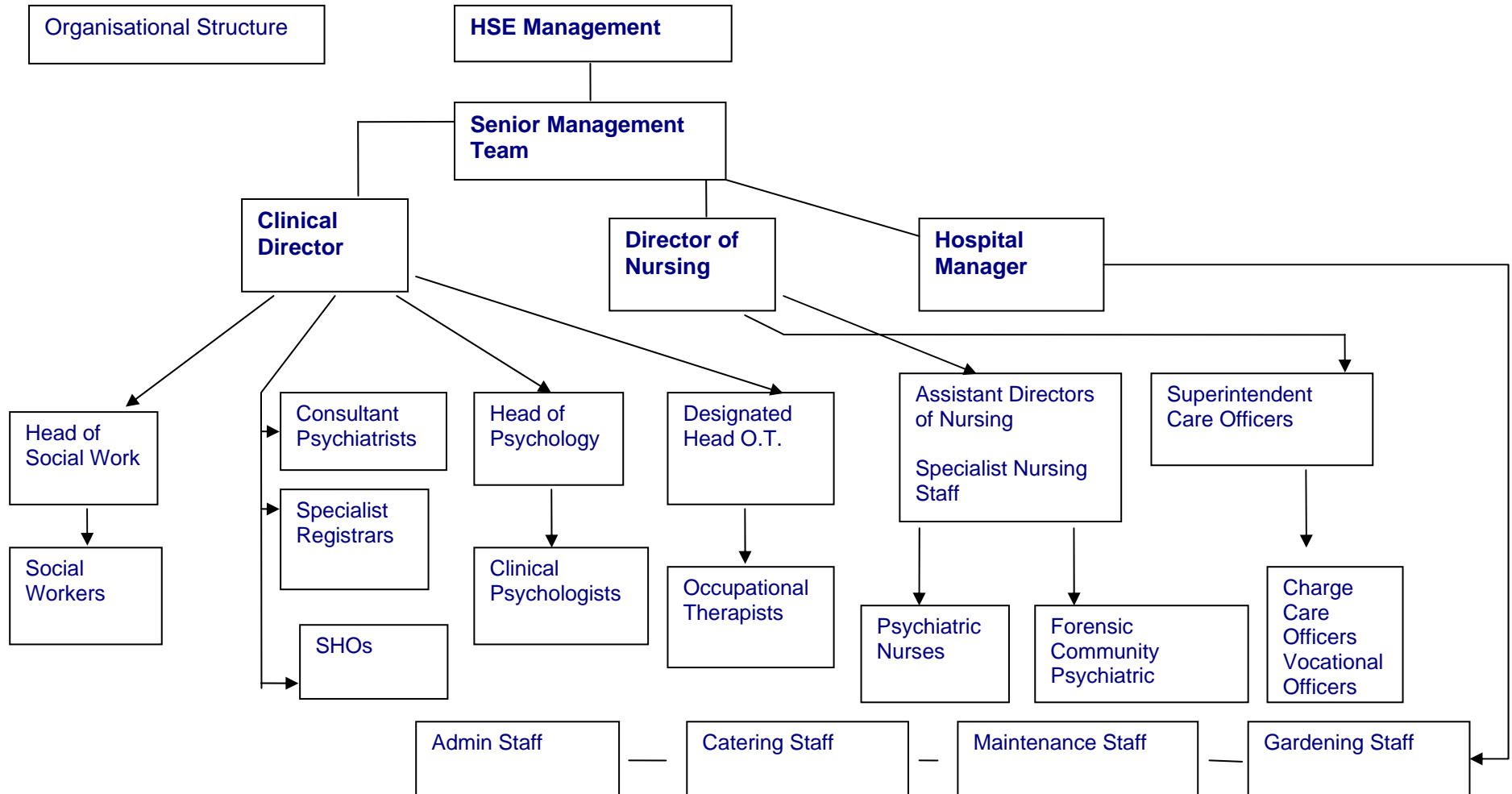
## **Inquiry Central Mental Hospital**

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therapists 2 senior, three basic and one assistant occupational therapist and 3 psychologists one senior and 2 basic grade. All five teams have responsibility for patients in all units except for Unit 4, which is clinically managed by one multidisciplinary team.

Unit staffing in the hospital is by nursing staff and care officers who work a two day shift system which alternates charge staff on the units between nursing staff and care officers. There is a care officer supervisor, assistant directors of nursing and a director of nursing. There is an outpatient facility at Ushers Island which is also attended by some inpatients. This provides a rehabilitation programme and occupational therapy.

Inquiry Central Mental Hospital



### **Forensic Mental Health Services Philosophy of Care**

The Inquiry Committee believe that forensic mental healthcare should be provided in a range of residential settings in particular conditions of security. Security refers to the security conferred by secure buildings and secure external spaces and facilities including monitoring systems but also to ‘relational security’ where it is the provision of high staff to patient ratios of well-trained staff allowing not only appropriate supervision and monitoring but also the opportunity for building good therapeutic relationships with patients which in large part confers security. The different levels of secure care provision are described below.

The Inquiry Committee believe the philosophy of care for all secure units should incorporate the following:

- The unit should promote the dignity, privacy and safety of all patients, balanced with the safety and security of the wider community.
- Each patient should have an individualized treatment plan addressing his/her psychiatric, psychological, psychosocial and spiritual needs.
- Patients should be involved in the care planning process so that care plans take account of individual circumstances, choices and expectations.
- A structured system of advocacy should be available to patients and service user involvement in service development should be encouraged.
- It should be possible to map out care pathways for individuals allowing people to move through the rehabilitation process with an absence of artificial barriers.
- The unit should provide a support system for the families and carers of patients and facilitate involvement with peer support networks.

In terms of the day to day service delivery each person in the care of the forensic mental health services should

- Undergo a period of assessment, which will identify the individual’s strengths and needs and facilitate a thorough risk assessment.

- Be allocated a key worker who will co-ordinate the patients care during their stay and ensure a co-ordinated approach to discharge/transfer back to his/her own area and other service where appropriate.
- Participate in regular multi disciplinary reviews of their care and be given every opportunity to contribute to their own care plan including their ongoing risk assessment.

**(a) Low Secure Forensic Units**

Low secure units deliver intensive, comprehensive, multidisciplinary treatment, care and rehabilitation for patients who present with a level of behavioural disturbance in the context of a serious mental disorder. Treatment and rehabilitation is provided, usually over a lengthy period, with ongoing risk assessment and review. Patients in low secure units will be admitted under mental health legislation and will present a less serious physical danger to others than persons requiring a medium or high secure treatment setting. Security arrangements provided are designed to impede rather than completely prevent those who wish to escape or abscond. Low secure provision should have a greater reliance on staff observation and support rather than physical security arrangements. Low secure units have an ethos of active rehabilitation and therefore emphasise patient access to acute and community services and promote a philosophy of community integration. Low secure units should be distinguished from Psychiatric Intensive Care Units (PICU) that provide short-term care of persons with disturbed behaviour in the context of acute illness.

Typical Service User Characteristics

- Admitted under mental health legislation
- Risk assessment indicates that this level of security is required
- Mix of offending and non-offending behaviours such as challenging behaviour, self neglect and deliberate self harm
- Persons who offend but do not get charged
- Risk predominantly to others



Typical Security Characteristics

- Perimeter security that impedes rather than prevents a determined escape attempt
- Secure exercise area
- Locked entrance doors
- High dependency areas
- Seclusion facilities
- Good levels of observation and support
- Alarm systems
- Appropriate environmental design including use of space to provide a restful environment with low levels of stimulation

Entry to low secure care will usually be from generic mental health services following a risk assessment, from court services where an inpatient assessment is required or from prison where a period of inpatient treatment is required and this level of security is indicated. Low secure care is therefore available as a resource to the generic mental health services for the management of persons requiring assessment and treatment in conditions of greater security than can be provided in the generic mental health services and teams working in low secure care services should have close working relationships with generic mental health teams so that there is ease of movement in both directions for persons requiring care and treatment.

Low secure units should provide a full range of treatment options i.e. pharmacotherapy, psychological therapies, psychosocial programmes and vocational training opportunities. Each low secure unit must have a clear link to community based residential facilities, whether these are dedicated facilities or shared with mental health rehabilitation services, in addition to having a pathway to transfer patients back to the generic mental health services in the person's local area.

Note: Good environmental design in forensic mental healthcare, in addition to producing environment layouts which enhance security, tends to make use of natural light, high ceilings, good sound-proofing, neutral colours, soft furnishings and other

design elements to promote a restful environment with low levels of stimulation and to maximize the feeling of space and freedom of movement within units.

**(b) Medium Secure Forensic Units**

Medium secure units provide a treatment environment for patients who present a serious but less immediate danger to others. Physical security protocols and procedures, supported by high levels of staff, should be sufficient to deter all but the most determined to escape or abscond. Patients accepted into medium secure services will present with a serious risk to others and the potential to escape or abscond.

Within the perimeter of the medium secure service a good range of therapeutic and recreational facilities and activities should be available. These facilities and activities should be comprehensive in order to meet the needs of patients who are not ready for leave into the community, but with an emphasis on graduated use of ordinary community facilities when possible.

Typical Service User Characteristics

- Formally detained
- Risk assessment indicates that level of security is required
- Offending behaviour
- Risk predominantly to others
- Significant capacity or risk to attempt to escape or abscond
- Serious but less immediate risk to the public if at large
- Non-Offenders with a history of violent behaviour whose needs cannot be appropriately met by local services

Typical Security Characteristics

- Perimeter fencing to a height of 3-4 metres with close-welded steel mesh, with bars at 12 mm centres in one direction

- Controlled access lobby to secure area, with outer and inner doors controlled by reception staff to form an airlock arrangement
- Where the fabric of the building acts as part of the secure perimeter of the unit the specification should be commensurate with preventing external access to the unit, and to ensure that contraband items cannot be passed to patients
- Provisions of exercise space internal to the building stock and exercise space with access to fresh air within the secure perimeter
- Provision of alarm systems
- Procedural security checks
- Locked doors to regulate access and movement of patients and visitors within the secure perimeter
- Appropriate environmental design including use of space to provide an environment with low levels of stimulation.
- Visiting facilities specifically separate areas for children.

The medium secure unit should be purpose built to provide up to date therapeutic facilities for service users. A modern medium secure unit will provide a high level of environmental security so as to allow maximum freedom of movement for individuals within the unit. Medium secure units must be staffed and managed by specialist forensic mental health staff and must have access to facilities at a lower level of security e.g. a staffed 24 hour hostel and/or easy transfer to a low secure unit in order to provide proper rehabilitation pathways for patients. Patients may also be transferred to high secure care if their risk status is changed. These units should be models of best practice providing a full range of treatment interventions i.e. pharmacotherapy, psychological therapies, psychosocial interventions and vocational training opportunities.

### **(c) High Secure Forensic Units**

High secure units provide a treatment and rehabilitation environment for those patients who would pose a grave and immediate danger to others if at large. Security arrangements should be capable of preventing even the most determined escape attempt or absconder.

Within the high secure perimeter a full range of therapeutic and recreational facilities and activities should be available. The comprehensive range of services, both recreational and clinical, acknowledge the severe limitations for patient access to community services and facilities.

### Typical Service User Characteristics

- Formally detained under mental health legislation
- Charged or convicted of a grave offence
- Assessed as being an immediate danger to others in the community
- Significant capacity for co-ordination of outside help to perpetrate an escape attempt or absconding
- Patients may have a high public profile
- Risk predominantly to others
- Non-Offenders with a history of violent behaviour whose needs cannot be met in medium secure services

### Typical Security Characteristics

- Perimeter fencing or escape proof wall to a height of 6 metres
- Access and egress to the secure area via regulated airlock arrangements for staff, visitors, patients and vehicles
- Regular monitoring and inspection of perimeter
- Monitoring of potential risk items through the secure perimeter
- Security checks of staff
- Security checks of all visitors
- Provision of exercise space internal to the building and exercise space with access to fresh air within the secure perimeter
- Educational, rehabilitation, therapy and recreational facilities for patients sited within the secure perimeter
- Appropriate environmental design including use of space to provide an environment with low levels of stimulation
- Provision of alarm systems
- Procedural security checks

- Locked doors to regulate movement of patients and visitors
- Specific visiting arrangements especially for children
- Regulated access by patients to Communication Systems and Communication equipment
- Monitoring of mail

Entry to the high secure service will usually be from the prison service where this level of security is required, from the courts under particular circumstances and from medium secure units. There needs to be clear protocols for transfer of persons from medium secure services to high secure care and conversely back to medium secure care when treatment in a high secure service is no longer indicated. A national high secure service will inevitably be geographically distant from family for a high proportion of service users and special care needs to be taken to preserve contact with families.

**WARD CONFIGURATION**

The C.M.H. dates from 1850 and service users and staff are accommodated in the original buildings apart from the admission ward and the women’s unit. It is the only forensic psychiatric facility in Ireland and accommodates service users across the range of security needs. At the time of the Inquiry there were 69 places available for men and seven for women. There is a male admission ward and two male medium secure wards for continuing care and rehabilitation. Unit 7 and the hostel are open units for service users at the later stages of longer admissions. The women’s service is provided on the one unit (Unit A) which accommodates women with widely different security needs.

**TABLE 3. 1 WARD CONFIGURATION**

<b>UNIT</b>	<b>NUMBER OF SERVICE USERS</b>	<b>DESCRIPTION</b>
Unit A	7	Women’s Admission Unit
Unit B	15 (10 operational)	Male Admission Unit
Unit 2	13	Medium Secure Unit
Unit 3	16	Medium Secure Unit
Unit 4	6	Special Adaptive Behavioural Unit
Unit 7	14	Low Secure Unit
Hostel Ward	10	Open Rehabilitation Unit

**STAFFING**

There are five consultant psychiatrist-led teams which are well supported in relation to occupational therapy, social work, other medical staff, community psychiatric nursing and clinical psychology. In order to preserve continuity of care the admitting team retains responsibility for service users from admission to discharge. This means that all five teams have responsibility for service users on all units except for Unit 4. Community nursing is linked with each multidisciplinary team but unit based staff work to all the teams except on Unit 4. A central rostering system means that

nursing and care staff do not form core teams for particular units. A two day shift system alternates the leads between nursing staff and care staff. The two shift leads do not necessarily meet regularly to plan the ward programme although there were exceptions to this with beneficial outcomes.

### **PRISON IN-REACH SERVICE**

The National Forensic Service provides an extensive mental health service to the following prisons: Arbour Hill, Mountjoy, Wheatfield, Cloverhill, Portlaoise, the Dóchas Centre and St. Patrick's Institution. The psychiatrists work closely with the community nursing team and prison staff in providing assessment and treatment within the prison estate.

### **OUT-PATIENT AND COMMUNITY SERVICE**

Usher's Island is a community rehabilitation facility in Dublin which provides a day programme on two days/week for up to ten inpatient users and four or five community service users. A further half a day/week is available for women service users. It is also used as an outpatient base where tertiary referrals can be seen and assessments provided for the Courts. The majority of service users who have spent at least two years at the C.M.H. are followed up by the C.M.H. teams including community forensic nursing and social work input. Transitional arrangements are put in place for the small number of service users returning to services outside the Dublin area.

### **LEGAL STATUS OF ADMISSIONS**

The majority of admissions to the C.M.H. are transferred from prison for short-term admission and the C.M.H. provides for longer-term treatment and rehabilitation for a proportion of service users. Service users at the C.M.H. are admitted under the following arrangements:

**Section 208:** service users are referred from another psychiatric hospital under Section 208 of the Mental Treatment Act, 1945. These service users have originally been detained in their local hospital of origin and then transferred.

**Section 207:** There are a small number of service users who are detained in the C.M.H. on Section 207 although this section of the Mental Treatment Act, 1945 is no longer in use.

**Ministerial Order:** Service users are transferred from prison on the signatures of two independent medical practitioners. They are viewed as detained and can be treated against their will.

**Hospital Order:** Service users are transferred from prison on the signature of one medical practitioner. They are viewed as voluntary service users.

**Guilty but Insane (G.B.I):** service users are admitted from the courts to the C.M.H. following a verdict of Guilty but Insane or if they are unfit to plead.

Changes in legal status of service users have occurred with the implementation of the Mental Health Act, 2001 and the Criminal Law (Insanity) Act, 2006.

### **CARE PROCESS WITHIN C.M.H.**

The Through Care Policy is the basis of the care process within the C.M.H. It aims to be an overarching structure with four component policies giving substance to the principles detailed. The four policies are:

- admission policy
- MDT roles and practice (as a service level agreement)
- discharge policy
- aftercare policy

The Through Care Policy applies to all patients within the C.M.H. It states that a care plan is to be formulated and communicated to the referrer regardless of the length of stay in hospital. The emphasis is on continuity of care from first referral through to discharge and aftercare. The rationale underpinning this is that a care plan will only be effective if there is agreement from the people involved, that they are able to participate as planned, and there is involvement of the patient and the carer in the decision making process. One of the main aims is to meet the needs of patients by carrying out an assessment of those needs, from a mental, physical and psychological



health perspective. In the forensic psychiatric service, this includes a detailed assessment of risk/relapse indicators required for patients and a strategy implemented to manage the identified risk.

### **Admissions**

The aim of the admission policy is to set out an operational description of the services provided to patients by the multidisciplinary teams and the optimal role of each member of the team, so that complementary and cooperative services are provided. The policy outlines the procedure applied to assessing a referral and arranging an admission. Initially, a Forensic Consultant Psychiatrist or a Senior Registrar and a Forensic Community Psychiatric Nurse assess a referral. If a referral is considered appropriate for admission, a preliminary care plan is devised and communicated with the appropriate unit in the CMH (Unit A or B). Upon admission, it is the responsibility of the Unit Manager to coordinate and supervise the delivery of care and treatment planned for the patient during their stay in the hospital. It is stated the person in charge of the unit should assign staff members to the roles of key worker/primary nurse, and associate keyworker/nurse, once notification of a pending admission has been received. The roles of the key worker/primary nurse and associate keyworker/nurse would be to carry out the admission procedures and help ensure continuity of care throughout the patient's stay in hospital. However, it was acknowledged by the service that a coherent keyworker system had not been implemented. This is discussed in greater depth in Sections 4 and 5.

### **MDT Roles and Practice**

The clinical governance questionnaire completed by the management team in the CMH states that all patients have a written care plan as part of their care management programme. The introduction of this care plan system has been a priority for the service over the last three years (and that all service users are involved in their care plan and their risk assessment). The involvement of carers is encouraged but with the consent of the service user. The social work department take the lead in contact with family.

Each MDT drafts and revises the Through Care Policy 1 and reviews the care plan at each case conference. There is a recognised proforma for the case conferences and all disciplines are expected to attend. The local CMHT is also invited to attend, but

unfortunately attendance is rare. The policy outlines that a named co-ordinator will take responsibility for implementing, evaluating and reviewing the plan on a regular basis. There must also be detailed contingency plans to detect and deal promptly with any problems that may occur. The Clinical Director is responsible for overseeing this process.

There is a separate nursing care plan for which nurses take responsibility. They are required to ensure the plan is formulated, and that this should involve involving the patient in the process at the earliest opportunity, while taking their mental state and risk assessment into consideration. In addition, there is an obligation to:

- Monitor, supervise and coordinate the delivery of the care and treatment in accordance with the care plan.
- Identify, through observation and communication with the patient, their needs and concerns and liaise with the other members of the team to aid their assessment of the patients needs.
- Make sure that outcome measures for each intervention are agreed, evaluated and revised as necessary.
- Ensure review dates are set.
- Record and report observations and progress, through attendance at team meetings and case conferences.

The role of the Assistant Director of Nursing/Senior Care Officer (ADON/SCO) includes the supervision of those in charge of the unit to ensure a high standard of care is being provided to patients on a daily basis. In addition, the ADON's are responsible for auditing nursing care plans

The Consultant Forensic Psychiatrist has a number of responsibilities which include assessing patients referred to the service, prioritising people for admission, ensuring the (TCP1) form is completed at each case conference, and recording the current treatment plan, the patients' progress, and the pre-discharge planning.

With regard to, the responsibilities of the social worker, psychologist and occupational therapist. However, the policy notes that within sixty days of admission the patient will have:

- a detailed psychiatric bio psychosocial assessment,
- a preliminary diagnostic formulation and medical treatment plan,

- a social work assessment report and plan,
- an occupational therapy assessment addressing where appropriate activities of daily living, rehabilitation and placement issues and
- a psychological assessment as appropriate of, neuro-psychological function, cognitive disposition and appropriate psychological treatment plan.

### **Discharge and Aftercare**

The policy outlines MDT roles in the discharge of patients and aftercare arrangements. It also notes that all discharges should be coordinated through the designated secretary. The secretary's role is to:

- Check planned discharges on a daily basis
- Attend the transfers meeting and record the decisions made regarding patient discharges
- Contact the prisons to arrange discharges, transport arrangements
- Where required ensure that the De-certification is completed
- Ensure all admission orders are given to the clinical director

The secretary also ensures that the patients' personal property is returned, including money. The forensic community nurses are involved in discharge planning and provide follow up care as agreed in the discharge plan. All discharges are reported to the duty ADON/SCO.

The aftercare policy states that all service users will have an aftercare plan which will be compiled when they are in hospital. The plan may involve liaison with other psychiatric services, follow up in a prison clinic or treatment and support in the community depending on the aftercare arrangements.

## **SECTION 4 – WOMENS SERVICE**

### **SECLUSION AND RISK MANAGEMENT**

Within the two sections examining individual units at the Central Mental Hospital, (Section four – the Women’s service and Section five – the male units), the use of seclusion and risk management strategies are commented upon. Both areas are covered in greater detail in subsequent sections of the inquiry report. Section six examines the practice of seclusion whilst section seven discusses risk management practices. However, as their use is commented upon, when examining the units in the service, it is helpful to briefly document the definitions of these two terms. The definition of seclusion is recorded in the Mental Treatment Regulations, 1961 (SI No. 261/1961) as the placing of a patient (except during the hours fixed generally for the patients in the institutions to retire for sleep) in any room alone and with the door locked or fastened or held in such way as to prevent the egress of the patient. Risk management is defined by the Clinical Risk Management Policy of the Central Mental Hospital as the process of measuring or assessing risk and developing strategies to manage that risk.

### **UNIT A: THE WOMEN’S SERVICE**

Unit A is the only unit available for women at the C.M.H. and therefore accommodates women with widely differing needs. The women’s service has been based in its current building since 2003 which was originally built as an adolescent unit. The unit comprises 7 bedrooms each with en-suite facilities grouped around a central living area. Individual access to rooms during the day is dependent on a personal care plan with patients on level 1 observations being allowed access to their rooms. Bathroom and toilet facilities on the ward are usually locked so that all women patients need to ask staff on each occasion if they wish to use these facilities. Television is available in each room but none of the women had a desk or writing area in their room nor an upright or easy chair.

A schedule of daily routine was available on the notice board in the unit. Room doors are opened at 8.30am and patients retire at 8.45pm. Scheduled therapies occur between 10.00am and 12.15 and 14:00 until 16:00 when visits can also occur.

Activities off the unit occur between 18:00 and 19:00 (gym, garden walks, GROW meetings, AA meetings, Bingo and music) and watching television between 19:00 and 20:00.

There are two seclusion rooms and one of the bedrooms is designated as a ‘step down’ room when special precautions are used at night. One of the seclusion rooms had no natural light only an internal window area that had been rendered opaque and neither had integral sanitation.

Meals are provided from the central canteen in a dining room on the unit and this room is also used for visits (excluding children’s visits) interviews and multidisciplinary team meetings. Breakfast is available at 9:00am, lunch at 12.30pm and tea between 17:30 and 18:00 which is the last meal of the day. The unit has a small kitchen but patients have only supervised use of the kitchen at any stage of their rehabilitation. There is no other facility for patients to make hot drinks. The furnishing and décor of the women’s unit is not of a high standard giving the unit an institutionalised feel and the furnishings did not appear to support a choice of daily activities. There is no area specifically available for patients who are well and able to enjoy this. Laundry facilities are available on the Unit but it is unusual for patients to do their own laundry with only one patient having access at the time on the unit.

There are two secure court yards, only one of which was furnished for recreational use and regularly available to patients at the time of our visit. The unit is non smoking and patients who smoke utilise the court yard area for this purpose.

### **Multidisciplinary Team**

Each of the five consultant led multidisciplinary teams can admit to the women’s service and hold weekly reviews of treatment and care plans on the unit. A keyworker system was said to operate on the unit and was felt by the staff to operate satisfactorily. However individual patients did not appear to know their named nurse and did not meet up with them on a regular basis.

There are five ward based nursing and care staff on duty during the day and two at night. Male and female staff work on the unit. The gender mix of staff on at night

ensures that a female member of staff is always on the unit. There is some additional ward based Occupational Therapy input for the women's unit but the lack of consistent involvement from nursing and care staff is seen to have considerable impact on the implementation of ward based activities and other initiatives.

### **Care Plan and Model of Care**

Each service user has a nursing care plan and a T.C.P. The T.C.P.s are reviewed at case conferences every 6 months which are attended by the service user, carer, and multidisciplinary team. Users did not believe they received copies of their care plans. The ward has a keyworking system in operation though there are no specific keyworkers allocated to an individual patient during the course of their care and not all of the ward staff undertake a key working role. The allocation of keyworkers is done on a daily basis. The focus of nursing interventions is through the nursing care plan. This is reviewed by nursing staff on Sundays though the patients are not part of the review and do not have a copy of the nursing care plan. Seclusion appeared to be used regularly and to be of long duration. This aspect of care is examined in more detail in the themed portion of the report. In contrast care plans appeared to show little use of alternatives to seclusion such as nursing a service user in her own room with constant observation.

### **Therapeutic Programme**

There appears to be good access to individual therapies which do not require specialised facilities although arrangements are constrained by a lack of interview rooms on the unit. Access to group treatment programmes appeared limited at the time of the visit although these were being set up. There is a ward programme posted on the notice board which includes a community meeting on Sundays although the user group did not think this occurred regularly.

Off the ward women service users can attend vocational training, industrial contract work, education, Industrial Therapy and art. Occupational therapy staff were particularly concerned about the paucity of appropriate activities for women and both staff and patients expressed concerns about the value and skill based goals of the Industrial Therapy Programme bearing in mind this is the most usual activity offered to women inpatients and utilises a large proportion of the available time.

Although women can be referred to the Wildwood Project it is necessary for a female member of staff to be present and it was unclear as to whether this could be facilitated. Women patients did use the Wildwood garden area for escorted leave on a regular basis.

Women can attend the gym between 18:00 and 19:00 each evening and this is welcomed by the resident group. Swimming sessions were said to be rarely available.

### **Risk Management**

All women are locked in their rooms between 20:45 and 8.30am. They are checked every fifteen minutes if they are on level 2 observation and hourly if on level 1. A risk assessment is undertaken as part of the care plan. Access to rooms during the day is reviewed as part of an individual care plan and varies according to service user need. With the exception of the two secure courtyards access to outdoor areas is not available to individual service users unsupervised at any stage of admission including those areas unavailable to male service users such as the grassed area behind the women's unit. Telephone calls may be made between the hours of 18:00 and 20:00 and these are always supervised and listened to by staff. Escorted leave, usually for shopping occurs when appropriate and unescorted leave can be utilised in the community. However it appeared to be unusual for longer stay residents to take up external placements such as college courses.

### **Service User Views**

All the women on the unit at the time of the visit completed the Forensic Satisfaction Scale (see Appendix 3) and met with members of the Inquiry Committee. The concerns of the service user group centred on what they perceived to be a lack of an individual approach to risk management and rehabilitation, the paucity and narrowness of activities available both on and off the Unit, physical health care and procedures with regard to seclusion.

The Inquiry were given to understand that it was usual for service users who were stable and utilising leave outside the hospital not to be supported in their rehabilitation on the Unit. Residents are not encouraged to do their own laundry and only have

supervised access to the kitchen facility. Unescorted leave in the court yards or grounds is not allowed and the user group did not consider the large grassed area behind the unit to be available at all. The user group was dissatisfied with the lack of desk and easy chair in their rooms. They reported that ward staff had not discussed options that might meet their needs while taking account of the mixed use of the ward such as provision of a light chair or fixed writing area. Although the user group were aware that at particular times the needs of service users for an intensive level of care might impinge on the care provided to other service users they considered the restrictions to be imposed on a rigid basis that was not directly linked to the needs of the resident group. They also felt very dependent on ways of working linked with particular staff rather than on a coherent ward culture. Users reported that when they asked for an explanation of a more restrictive approach they were told “that’s the rule”. The group also considered that responses to their suggestions for change were commonly dismissed on the grounds of security. However a recent request for keeping a rabbit in one of the court yards was being considered supportively.

The user group considered the range of activities available to be severely restricted. Although the Wildwood garden project is said to be available to women service users the group felt this was not the case as reliability of provision of a female escort would be required. Women were able to attend industrial therapy but this work did not appear to be linked with specific goals in the acquisition of skills. The user group expressed considerable dissatisfaction with the work in industrial therapy and stated that they still attend when no work is available. The group felt under pressure to attend industrial therapy rather than occupational therapy options and were acutely aware of the tension in this regard between professional groups. Women can attend education, art and woodwork but there is no availability of creative skills such as textiles and home economics. Women can only attend Usher’s Island on one day a week. Arrangements for child visiting were viewed positively with prompt and thoughtful support in this area.

The user group were particularly concerned about women’s clothes, including underwear being removed and about women invariably being dressed in protective clothing as part of the seclusion procedure. There was a perception within the user group that if they did not comply that male staff might attend and remove their



clothing. The user group believed that policy allowed male staff to remove their underwear.

Inquiry Committee members were informed by the user group that women were only allowed to use tampons during periods of seclusion when menstruating. Staff confirmed that this was the case. This practice was not dependant on individualized risk assessment but applied to all women in seclusion. The user group also reported that patients in seclusion had to use a special spoon for meals. One user reported finding this difficult and resorting to using her hands.

The Inquiry Committee were extremely concerned about the service user feedback about seclusion procedure and made immediate contact with the Director of Nursing to ascertain if it was the case that women's underwear was routinely taken from women in seclusion and whether male staff were involved. It was told by the D.O.N. that women's underwear was removed when placing women in seclusion, to prevent self strangulation. During the course of the Inquiry efforts were made by Senior Management to find alternatives. At the time of writing the report no alternatives had been found, but it was stated by the D.O.N. that underwear would only be removed in accordance with individual risk. Although male staff were present during the seclusion process Senior Management staff said that male staff were not involved in the removal of underwear.

The Inquiry Committee was also informed that service users had to inform staff of the dates of their periods and these were entered in a log book. Users described this as humiliating. The group also had concerns about health checks being facilitated such as cervical screening. The general view was that they were not enabled to access well women clinics and that alternative provision had not been offered.

### **Staff Views**

There was much concern from staff about how much the disturbance of a small number of service users impacts on other's wellness. There was a widespread agreement that having women with different security, treatment and rehabilitation needs within the same environment caused difficulties in establishing a therapeutic environment based on individual need. The range at the time of the visit extended

from high dependency combined with significant risk to later stages of rehabilitation. Staff expressed some disappointment that the women did not have access to the gardens because of security concerns. There were, however, some joint activities that women attended in mixed areas such as GROW, and VEC and this was viewed as a positive development. The staff interviewed were keen to develop further services and links with the OT department to enhance the therapeutic activities on offer and for these to be patient focused. The broad management team also emphasised the need for purpose built women's facilities in the short-term options for step-down rehabilitation facilities which would also help the problem of unmet need for women within the women's prison system in Ireland.

### **Seclusion**

The staff viewed that seclusion was used as a last resort on the ward and that it was only used when the patient was seen as a high risk of harming others or themselves. There was also the view expressed that each individual action was reviewed on an individual basis. There was some discussion about the procedures adopted when someone was admitted to the unit. It was stated that the decision would be based on individual need. The minimum requirement would be for someone to be placed on level two observations for fifteen minutes. Some new admissions are placed in seclusion on admission and staff felt this could include management of self harm.

### **Staff Development**

There was a general consensus that the support for staff development was of a high standard and there were good staff education opportunities. However, none of the nursing staff had received any clinical supervision regarding their practice although there were some informal peer support meetings on occasions (usually following a difficult incident).

## **FINDINGS – WOMEN’S SERVICE**

- 1. The décor and finishing of the unit is not of a high standard and furnishings did not support a wide choice of daily activities.**
- 2. Only one of the small secure courtyards on Unit A is furnished for recreational use and regularly used by patients. The courtyard in regular use is pleasant and has further potential.**
- 3. The seclusion rooms do not have associated toilet facilities. One of the rooms has no natural light and is not of an acceptable standard for use.**
- 4. The environment provided for women does not include step down facilities.**
- 5. Women patients are not nursed according to their individually assessed needs and some patients are locked in their rooms when their risk can be satisfactorily managed in other ways.**
- 6. Keyworker arrangements on the ward are inadequate being based on a shift nurse pattern rather than promoting continuity of care over an extended period.**
- 7. A number of patients did not seem familiar with their care plan and said they had not received a copy.**
- 8. Seclusion appears to be used regularly with little use of alternatives to seclusion. Women’s underwear is routinely removed during seclusion and they are not allowed appropriate choice of sanitary protection.**
- 9. Policy on the unit allows male staff to be involved in the restraint of women patients. Involvement of male staff did not appear to be confined to exceptional situations.**
- 10. Women patients have good access to individual therapies that do not require specialised facilities. Wider rehabilitation including activities of daily living and creative use of leisure seems very limited. Women were not allowed to prepare their own drinks or meals or to regularly do their own laundry.**

Activities off the unit were restricted with an over emphasis on routine contract work for which there was little enthusiasm.

11. Child visiting is positively managed by Social Work and nursing members of the multidisciplinary team. Social Workers are actively engaged in family contact and support but there appeared to be variability in how far unit based staff were integrated in the approach in this important area.
12. In relation to physical healthcare needs women had access to the gym on a daily basis but limited availability of brisk walking or swimming. Access to appropriate health screening was not available at the time of the Inquiry.
13. All mealtimes are currently within one 8 hour period out of 24 hour period and it is unlikely this reflects patient preference.
14. Ward based staff work with staff from other disciplines (consultants, NCHD's, social work, occupational therapy and psychology) across all multi-disciplinary teams which may contribute to the difficulties in developing new ways of working with this challenging group of patients.

#### **RECOMMENDATIONS-WOMEN'S SERVICE**

1. The physical environment of the women's unit should be improved. Immediate attention should be given to refurbishment and the enhancement of both courtyard areas.
2. Seclusion facilities should be reviewed and the most unacceptable seclusion room taken out of use.
3. The Inquiry Committee supports the development of step-down rehabilitation facilities for women and commends the links being developed with local community facilities. In the short term there should be discussion within the staff and patient group of creative ways to facilitate rehabilitation as patient's progress.

4. **Women patients should have a care plan that reflects their individually assessed needs and should not be locked in their rooms regardless of their risk management.**
5. **Continuity of staffing on the women's unit is essential to facilitate effective keyworking and to develop a ward culture sensitive to the needs of women.**
6. **The use of seclusion on the unit should be reviewed and the practice of routinely removing women's clothes and underwear in seclusion should cease.**
7. **Control and restraint on the women's service should be carried out by female members of staff save in exceptional circumstances. We recommend that additionally the policy should not allow removal of female patients' clothes by male members of staff. Training in gender aware approaches to control and restraint would be helpful.**
8. **Patients should be fully conversant with their care plans and receive a copy of their care plan. This should include a rehabilitation plan with particular emphasis on the maintenance of skills of daily living.**
9. **Consideration should be given to how best unit based staff can work with social work colleagues in providing an integrated approach to family contact.**
10. **Access to appropriate screening in women's health should be facilitated. Such access should not be dependant on service development.**
11. **There should be some choice available with regard to eating later in the day if this is preferred by individual patients.**
12. **The Inquiry Committee considers that the provision of the women's service should be facilitated by a consultant led team that would best support the development of a cohesive culture and treatment programme. It is recommended that a unit based multi-disciplinary team for the women's service is developed with opportunities for professional links including visits and exchanges of staff with other forensic mental health services facing**

**similar challenges of providing for patients with differing dependency and security needs.**

## SECTION 5 - MALE UNITS

### UNIT B

Unit B is the first point of admission for all male service users and replaced Unit 1 which has now closed. The unit also accepts male service users transferred from other units.

The operational policy for this unit states that the male admission unit will provide professional multidisciplinary care for service users admitted so as to

- Respect service user rights
- Enhance service users' health and alleviate suffering
- Ensure that service users' and others are at all times in a safe and therapeutic environment
- Facilitate family access
- Respect the dignity and choices of service users' at all times.

Unit B has 15 single bedrooms with en-suite facilities. Currently only ten of the beds are in use due to staffing issues. It was reported that there were insufficient nursing/care officer staff to increase the patient population of the ward. There were also safety issues pertaining to the environment. There are two seclusion rooms, a day room, dining room, showers, toilets, an office, interview room, meeting room, kitchen and clinical room. Outside the unit there is a secure exercise area and a smaller area for people who require fresh air and integration with the rest of the unit following a period in seclusion. The secure area external to the unit is small, has no grass area, no shelter and limited stimulus.

The objectives of the unit are

- To set achievable goals at the start of the period on the unit and review these weekly at M.D.T. meetings held on the ward.
- Involve the service user in the process of agreeing motivational goals and behavioural goals.
- To ensure the safety of all service users.

- Administering, for each service user a holistic, bio-psycho-social assessment of their psychiatric history and high risk and challenging behaviours to inform their treatment and care plans and therapeutic interventions.
- Develop a treatment and care plan for the service user which promotes positive mental health choices and minimises negative maladaptive challenging behaviours.
- Collaborate with the service user in the development of a treatment and care plan and a daily activity structure.
- To enhance treatment and rehabilitation opportunities.
- Facilitate onward movement towards less intensive and less restrictive environments, usually within the community, within a foreseeable time scale.

### **MULTIDISCIPLINARY TEAM**

Each of the five consultant-led M.D.T.s admit to the unit on a rotational system. Service users will remain the responsibility of the admitting M.D.T. during their stay in the service. Each M.D.T. holds a weekly review on the unit when treatment and care plans are reviewed. A ward based team worker system has been introduced so that a “keyworker equivalent” will always be on duty. Each team worker is responsible for coordinating the daily activities of the service user. There are seven staff on duty during the day and three at night.

### **CARE PLAN**

Each service user has a preliminary M.D.T. multi agency case conference arranged within two weeks of admission leading to a treatment and care plan (T.C.P.1.) which takes account of a detailed risk assessment and risk management plan (T.C.P.2. and HCR-20)

### **THERAPEUTIC PROGRAMME**

Music and art groups take place on the unit and service users have access to the gymnasium and swimming pool, accompanied by staff. Since the unit opened it is reported that service users have more choice in regard to whether they wish to attend the gym or pool. Service users on this unit do not have access to occupational activities off the ward.



## **RISK MANAGEMENT**

All service users are locked in their rooms at night which have in-room sanitation and a nurse call button. It was reported that service users are checked every 15 minutes if on level 2 and hourly if on level 1 when they are in their room and this is recorded. Service users are denied access to their rooms during the day. CCTV is used for all external entrance/exit doors and in the main exercise area, but is not used internally on any corridor, or room in the unit. As part of the care plan a risk assessment is undertaken. There are two seclusion rooms both with sanitation. There is an area outside the unit, called the airing court which is used for people who are in seclusion to have access to fresh air. It appears from records available that up to one third of new admissions are placed in seclusion. It was reported that when service users go out into the external area all patients on the unit must go out. All service users are supervised in the bath.

## **STAFF VIEWS**

The staff interviewed outlined a number of issues. They were concerned that the secure external area was small, had no grass area, no shelter from the sun or any scope for stimulating activities.

Staff suggested that Unit 1 should be renovated to provide more step down facilities in order to speed up admissions from prison.

Activities on Unit B have increased and more access to the gym and swimming pool and it is hoped to further increase activities on the unit. Currently service users do not attend activities off the unit but it was suggested that a purpose built central O.T area would be of benefit.

It was reported that all M.D.T.s carry out their meetings on the unit and this has been a welcome innovation enhancing communication and service user care. The keyworker system is in its infancy and is hindered by the lack of core staff on the unit. All staff have completed the RAID training programme. It was reported that the maintenance of the unit can be problematic and getting repairs done relies on staff from off site, which causes time delays.

### **SERVICE USER VIEWS**

The user group participated in completing the Forensic Satisfaction Scale (see Appendix 3) but it was not possible to have a separate group to discuss wider views. Individual service users on the Unit did not wish to meet up with the Inquiry Committee.

### **FINDINGS-UNIT B**

- 1. Five beds are not in use due to staffing and environmental issues at the time of the visit**
- 2. The inquiry committee found that efforts had been made, even in the absence of continuity of staff, to introduce a keyworker system**
- 3. It appears from records that most patients admitted to Unit B are placed in seclusion independently of any risk assessment**
- 4. The secure outside area is too small and lacks a grass area and shelter**
- 5. The unit was not self staffing**
- 6. Five multidisciplinary teams have access to the beds on this unit**
- 7. All patients are locked in their bedrooms at night and there is no access to their rooms during the day**
- 8. There was no clinical supervision for the unit based staff**
- 9. Unit based staff reported that they were not involved in the planning of this unit. However the Senior Management Team informed the Inquiry Committee that there was a comprehensive consultation process.**
- 10. The physical environment needed some attention**
- 11. All patients were supervised in the bath independently of any risk assessment**

### **RECOMMENDATIONS-UNIT B**

- 1. Appropriate resources and environmental changes should be made to ensure the five beds not in use on the unit are commissioned.**

- 2. The use of seclusion must be in line with the rules on seclusion published by the Mental Health Commission on the 1<sup>st</sup> November 2006. Alternatives to seclusion must be examined and documented in the patients care plan.**
  
- 3. Access to bedrooms during the day should be determined primarily on an individual basis and should be determined by the risk posed by the individual patient.**
  
- 4. The secure facility outside the unit should be redeveloped to ensure that the needs of the patient are met and that the environment has appropriate and safe facilities.**
  
- 5. All essential maintenance work should be carried out and a regular maintenance programme in place.**
  
- 6. The need to supervise patients in the bath should be determined primarily on an individual basis and should be determined by the risk posed by the individual patient.**

**(Recommendations pertaining to this and other units are in the overall recommendations on Page 81)**

## UNIT 2

### DESCRIPTION

The unit is described as a male medium secure unit. It cares for patients designated as having a higher risk and a higher dependency than Unit 3 (which is also described as a medium secure unit). It is reported by the Senior Management Team that Unit 2 has a higher staff to patient ratio than Unit 3. Unit 2 is located on the first floor of the main building in the Central Mental Hospital. The unit is accessed from; the ground floor, Unit 3, the dining room and the exercise yard, via two stairwells. The unit has 13 bedrooms as well as one seclusion room.

The unit has a day room, nursing office; kitchen, clinical room and interview room, bathrooms and toilets, at one end of the unit and with bedrooms are along one corridor at the other end of the unit. The patients eat their meals at the ground floor dining room with the kitchen on the ward used for making tea and snacks.

The unit has a main sitting room which appeared comfortable and spacious and patients relax here in the evening. Along one side of the unit is a long corridor which is where the bedrooms are located. Each patient has an individual room. None of the bedrooms have en suite facilities. The patients are locked in their room at 9pm and patients are required to request staff to allow them out to use the toilet. There is variability between shifts as to whether the washing facilities are available. When the bathroom facilities are locked there is no hand basin for use after using the toilets. The ward staff room is near the main social area away from the bedrooms. The unit decorations look fairly worn with this commented upon by both ward staff and patients though it is acknowledged that it is difficult to keep an old building clean.

The operational policy for Unit 2 states that the unit delivers a service for patients who have progressed in their treatment but are not yet ready for discharge from the hospital but no longer need the high levels of relational and procedural security of the male admission unit. Patients are transferred to the unit from the male admission unit (Unit B). The main progress is through Unit 3 and then onto the low secure units. However, there is often a wait for transfer to Unit 3 when appropriate progress has been made. If anyone becomes unwell or is causing concern, they are normally transferred back to Unit B where they then wait until another a vacancy becomes available on the Unit.

## **SECURITY**

The unit is locked though the residents are free to go around the grounds of the hospital with an escort. Residents may be on Guilty but Insane status or under section 208 of the Mental Treatment Act, 1945. There is a seclusion room in the unit though this is used sparingly. If someone requires either more intense supervision or seclusion it is usual for the patient to be transferred back to the admission ward. The patients are locked in their room from 9pm. Until recently, patients slopped out during the night but this practice ceased in early 2006. However, during the course of the inquiry, there were many complaints from patients and also carers of the time it took staff to come to let patients out of their rooms to go to the toilet. A number of patients told of banging on their door for up to half an hour before the door being unlocked. This had the additional problem of the banging causing other patients to wake up. In addition, steel window shutters are also secured over their windows. This is due to security concerns that the patients would be able to smash their windows and either break out of the ward or harm themselves on the broken glass. The patients, carers, and many staff, noted that this made the rooms airless and stuffy and consequently these rooms were uncomfortable to sleep in during hot weather. We have been informed that subsequent to our visit, the steel window shutters were removed and replaced with Marcolon/Perspex windows.

## **ACTIVITIES**

There is a ward programme which details the weekly activities the patients are able to attend. The majority of the patients undertake sedentary activities on the unit such as watching television, playing play station games or participating in groups (wellness, current affairs, anxiety management, relaxation) on the unit. Some of the patients do go to one of therapies within the grounds of the hospital such as the Garden Project, Industrial Therapy, or the Wildwood project though attendance at these projects does not always occur, as this is dependent on sufficient staff being able to take them to the therapies. None of the patients are allowed to leave the hospital on unaccompanied leave and their only outside contact is through visits from family members which are held in the dining room on the ground floor of the hospital. Family visits with children visiting are held in the Seomra.

There has been a monthly meeting with senior management team introduced since the end of 2005. The patient group did not think that this has produced much change in the ward environment and were unhappy that some of their concerns did not seem to have been acted upon.

### **STAFFING**

The unit has five or six staff on the day shift and three at night. There is an alternating shift system between care officer staff and nursing staff. There is a CNM2 in charge of one shift and a senior care officer in charge of the corresponding shift. Apart from these two members, the staff are not permanently placed onto the unit though many are mainly allocated to this unit. Overtime was also used to staff the unit. The staff further stated that they thought there was no cohesive nursing/care officer structure reporting to the CNM2 and Senior Care Officer to support policy implementation.

### **MULTIDISCIPLINARY TEAM**

All five multidisciplinary teams have clinical responsibility for patients in the unit 2. Some multidisciplinary team meetings are held in the unit and some in the Boardroom in the main building. There is no key worker system within the ward staff. The ward staff in particular report a limited involvement with other MDT members and indicated that they had minimal input in these meeting and in the planning of care. A number of comments from ward staff show that they perceived their views as not being considered by the MDT. One staff member stated that their opinions were never asked for from SMT nor Medical Staff and when they did express a view these were not valued. Within the MDT meetings, there was a ward staff representation at some times but there had never been a request for a ward/nursing report. One ward staff stated that that they read out ward staff notes and then the rest of the team discussed the care of the patients amongst each other. The ward staff also stated that one difficulty was in attending the MDT meetings was that some MDTs were on the unit and some were not. Another ward staff member commented that there is no way of challenging procedures and that “we act as bouncers within the case conference” and that ward staff were viewed as playing a predominantly custodial role. They also voiced concerns that there would often be no feedback to ward staff from other professionals about MDT decisions unless there was a specific concern. Ward staff

also had not input into the TCP. It was generally viewed that more attention was paid to the ward staff view at the weekly bed meeting.

## **PATIENT VIEWS**

### **Themes**

There were general views from the patient group that their care was of a reasonable standard although certain areas caused difficulties and that they were able to talk with staff about issues.

However, some concerns were expressed about specific areas.

### **Locking of rooms at night**

The patients did not like the fact that everyone was in their bedroom with the door locked from 8pm onwards. This was a blanket decision with no assessment of individual risk amongst the patients. The practice of slopping out was stopped in early 2006. However, many patients complained that they would have to bang on their doors for some considerable time before they were allowed out to go to the toilet by the night staff.

### **Steel Shutters on the windows**

In addition to their concerns about being locked in their rooms, another big area of concern was detailed in relation to steel shutters in the bedrooms which were shut for security reasons at night. There were numerous complaints about the stuffiness in the rooms that these shutters engendered as well as the feel it gave to the ward. We have been informed that subsequent to our visit, the steel window shutters were removed and replaced with Marcolon/Perspex windows.

### **Outside Shop**

There were a number of complaints associated with the outside shop that had the contract to supply the patients with goods. The outside shop that delivered to the hospital was viewed as expensive and there were also problems with the delivery of the goods. There seemed to be no regularity with time of delivery of goods and that this often meant that there were some period of time before the goods arrived. Ward staff agreed with this view. Subsequently in written correspondence from the Senior

Management Team it is reported that the Senior Management Team are aware of this issue and have consulted with the patients regarding this. The Senior Management Team believe as a result of this consultation that the patients preferred having access to an outside shop. This issue needs to be resolved.

### **Smoking ban**

There were a number of complaints from patients about not being allowed to smoke within the building. Many patients smoked and didn't like the ban, primarily due to the fact that there was often a wait of two to three hours between being able to smoke. These complaints were supported by the ward programme that detailed the times that were allocated for smoking in the yard on the ground level in the Hospital building. There were also complaints from the non-smokers in the unit as they would have to go to the yard with the rest of the ward even though they may not want to especially in the winter when it may be cold and rainy. The ward staff stated that the reason for this was that there were not enough staff to ensure security if some patients were on the unit and some were in the yard. In the discussions with the Assistant Director of Nursing, they acknowledged that a potential solution might be to allow wards 2 and 3 to go to the yard together and this would allow some staff to be left on the ward together to supervise the patient who did not wish to go to the yard.

### **Information**

Some of the patient group were critical of the limited amount of information given and discussion regarding legal information and more importantly regarding care plans, and future care and potential discharge. Many also stated that they had not been aware of their care plans with no discussions about their care and consequently these were not being signed (as per policy). The overall view of the patient group was that decisions were made about their care excluding them and then fed back to the patients. This lack of inclusion was compounded by the fact that there was no keyworker system in place to facilitate discussion about their care. There was also a lack of discussion with regards to discharge and the potential of going back home.

Some patients also reported about individual unaccompanied parole suddenly being stopped and no explanation perceived to be given. The response was that there was no way of discussing this and that to do so may result in non-specific negative consequences. Therefore, the response would be that this would have to be agreed to.



There was no evidence to substantiate the view that disagreeing with decision had resulted in any untoward consequence for the patient group though this was obviously their belief.

### **Parole**

The patient group also noted that parole in the grounds often could not be taken as there were insufficient staff to undertake this. The ward staff also agreed that this was the case.

### **Seclusion**

One of the patients alleged that another patient had been secluded as he had complained of feeling suicidal. We were unable to find any evidence to support this allegation.

## **STAFF VIEWS**

### **Physical Environment**

The staff expressed concerns about the conditions that they and the patients had to work and live within. Ward staff complained that the ward cleaning (mopping floors, washing dishes, toilet areas) often had to be undertaken by the ward staff. Although contract cleaners had been employed, they only came to the ward once per day and some staff expressed the view that that they only gave the ward a cursory clean in the morning. However, there was also some indication that a more thorough clean occurred on a weekly basis. The ward staff stated they were also unhappy that there were no areas for staff on the unit where they could take their break (and eat sandwiches). The alternatives were to have their break in the nursing office or communal area, or to go off the ward.

### **Lack of Privacy**

The lack of privacy within the toilet and bathroom areas was viewed as being unacceptable with patients having to bathe in communal areas meaning that other patients could see them if they were required to use the bathroom facilities. There is no privacy within the toilets and showers.

### **Staff Development**

All of the staff interviewed were aware of the induction programme that lasted three to four weeks. Most staff viewed this as sufficient in giving them an overview of the main aspects of the service. The ward staff were appreciative of the courses on offer from the staff development programme and thought there were a good range of options and stated that they were encouraged to engage in those opportunities on offer.

### **Supervision**

However, one area that was lacking was the fact that none of the ward staff interviewed had been involved in supervision.

### **Model of Care**

No model of nursing care was used on the ward. The ward staff acknowledged this deficit. The service have informed the inquiry that there is a plan to implement the Tidal Model (a model of mental health promotion) across all units,

### **Seclusion**

The ward staff reported that they could not remember the last time that a patient was secluded in the Unit. It was more usual for a patient requiring or being viewed as a risk to themselves or others to be transferred back to Unit B. One drawback in this procedure was that the patient would not be able to come back to Unit 2 until they had “worked their way through the system”.

### **Security**

The view of the staff was that the maximum number of patients on the ward that they viewed as needing medium secure care was six and that the other patients could be cared for and managed in less secure environments.

## **FINDINGS-UNIT 2**

- 1. The uniform locking of bedroom doors at night is unacceptable**
- 2. Although the practice of slopping out had ceased, patients now had to bang on their bedroom door to be taken to the toilet**

**3. On the day of the visit the bedrooms were stuffy and had steel shutters on the windows, which were locked at night. There was no means of ventilating the rooms.**

**Subsequently the inquiry committee have been informed that the shutters have been removed and replaced with macrolon Perspex, which is an improvement but still leaves the problem of inadequate ventilation**

**4. Five multidisciplinary teams have access to the beds on this unit**

**5. Unit based staff felt under represented in the multidisciplinary teams and undervalued at team meetings and case conferences.**

**6. The venues for team meetings varied between the unit and the conference room**

**7. There was no keyworker system in the unit and no model of care.**

**8. Many patients had little knowledge of their care plan and some stated that they did not have a copy of their care plan**

**9. The unit was not self staffing**

**10. There was no choice allowed in whether the patients went outside for smoking breaks**

**11. There was little access to the grounds for the patients. Quite often there were insufficient staff to escort the patients**

**12. No patients are considered for unescorted parole in the grounds**

**13. There was a time delay in moving patients from unit 2 to unit 3 for continued rehabilitation**

- 14. The cleanliness of the unit was not always satisfactory**
- 15. There was a lack of privacy in the toilets and bathrooms**
- 16. There was no clinical supervision for the unit based staff**
- 17. There was a lack of information available to staff on the unit from the management team on issues pertaining to audit and service development**
- 18. A number of patients complained about the over pricing in the shop outside the hospital that they had to use.**
- 19. The courtyard available to the patients lacked any stimulus and was not conducive to recreational use due to its dilapidated state and oppressive façade. It looks tired dated and custodial**

#### **RECOMMENDATIONS-UNIT 2**

- 1. The problem of ensuring that the bedrooms have appropriate ventilation must be addressed.**
- 2. Patients should be given a choice whether they go out to the courtyard for smoke breaks.**
- 3. There should be sufficient resources to ensure that patients have access to fresh air.**
- 4. The courtyard facility should be redeveloped to ensure that the needs of the patient are met and that the environment has appropriate and safe facilities.**
- 5. The facilities in the toilets and bathrooms should be of sufficient standard to maintain the patients dignity balanced with risk factors.**

- 6. There should be a clear system of communication between the Senior Management Team and the units' staff.**
  
- 7. The patients' issues with the use of the external shop should be addressed.**

**(Recommendations pertaining to this and other units are in the on Page 81)**

### **UNIT 3**

Unit 3 is a male medium secure unit situated on the second floor of the main C.M.H. building and is accessed by two flights of stairs. It is a locked ward of 16 beds and provides medium security and accepts service users transferred from Unit 2.

All service users have their own bedrooms which are locked at night. There are three larger bedrooms and 13 small bedrooms. There is no in-room sanitation. There is Perspex on the windows. Service users can access rooms during the day.

There are two day rooms and a locked quiet room which is used for interviews groups and meetings. There was a pool table and two televisions. There was also a small kitchen. Service users use the wide corridor for leisure activities such as card playing.

Service users go to the main dining room with Unit 2 for their meals and are escorted by staff. Service users also go for smoking breaks to an outside courtyard and must go outside for these whether they smoke or not. Visiting only occurs in the main dining room.

### **CARE PLAN**

Service users had a nursing care plan and a T.C.P. The T.C.P.s are reviewed at case conferences every six months which are attended by the service user, carer nursing staff and multidisciplinary team. Only a small number of service users had copies of their care plans and some were unaware that they had a care plan. There is no keyworker system in place but staff are assigned to service users in a multidisciplinary team. Staff provide a report to the M.D.T. and for case conferences.

### **MULTIDISCIPLINARY TEAM**

There are five multidisciplinary teams with input into the unit. Team meetings are held weekly, either in the unit or in the boardroom. Staff complained that attending the boardroom for team meetings was logistically problematic.

## **THERAPEUTIC ACTIVITIES**

There is a printed activity sheet for the unit as a whole. Most service users are involved in activities off the unit and attend the V.E.C project, the garden projects, Wildwood and Industrial Therapy. There is access to the gym and swimming pool which service users attend individually. Service users may access the kitchenette in the evening with staff.

## **SECURITY**

All service users are locked in their rooms at night. Slopping out had recently ceased. Service users who wished to use the toilets must knock on the door of their rooms to attract the attention of the nursing staff. Service users complained that they could be waiting for up to 30 minutes before getting to the toilet and felt that slopping out was a better option. All service users have meals in the C.M.H. main dining room. As there is no smoking allowed on the unit, all service users must leave the ward to go to the courtyard for smoking breaks, irrespective of whether or not they smoke. In this unit, depending on current risk assessments, service users may have escorted leave on the grounds of the C.M.H..

## **SECLUSION**

There is no seclusion on the unit.

## **STAFFING**

There are six staff on duty by day and three staff on duty at night. It is reported that this reduced to 4 staff from 5pm to 9pm. The staff are part of a rotational two day shift system in the C.M.H. involving both nursing staff and care officers. There is central rostering which causes difficulties in continuity of care.

## **SERVICE USER VIEWS**

The Service User group raised a number of issues.

There were complaints about the lack of money available to them which amounted to €2.00 per day. Those that attended Industrial therapy received €100 every year. They complained that the shop from which they ordered personal goods over-charged and would like a shop in the C.M.H.. The food was cold in the dining room. They complained that at night they had to wait 30 minutes for staff to open the door for

them to go to the toilet. Light switches were requested inside the bedrooms. Some felt that there was a threat that if they did not behave they would return to more secure environment which made them reluctant to talk about any symptoms they might have.

The Service Users said that they met with the S.M.T regularly and that things such as the menu and food had improved. They said that they met with the doctors but less so with social workers or occupational therapists individually. They felt that there was a shortage of individual therapy and although they signed their care plans they felt that their choices were not being taken into account.

The service users stated they had limited knowledge of the Mental Health Act, 2001 or their rights under the Act. The service users who were Guilty but Insane referred to the prospect of indefinite stay in the C.M.H. They felt that there was no hope of getting out of the C.M.H.. They also felt that getting out does not depend on recovery or getting well.

### **FINDINGS-UNIT 3**

- 1. The uniform locking of bedroom doors at night is unacceptable**
  
- 2. Although the practice of slopping out had ceased, patients now had to bang on their bedroom door to be taken to the toilet**
  
- 3. Unit based staff felt under represented in the multidisciplinary teams and undervalued at team meetings and case conferences.**
  
- 4. The venues for team meetings varied between the unit and the conference room**
  
- 5. There was no keyworker system in the unit and no model of care.**
  
- 6. The unit was not self staffing**



- 7. There was no choice allowed in whether the patients went outside for smoking breaks**
  
- 8. A number of patients felt that there was a threat of being moved to Unit B if they became unwell**
  
- 9. The courtyard available to the patients lacked any stimulus and was not conducive to recreational use due to its dilapidated state and oppressive façade. It looks tired dated and custodial**
  
- 10. The Perspex on the bedroom windows leaves the problem of inadequate ventilation**
  
- 11. Five multidisciplinary teams have access to the beds on this unit**
  
- 12. There was a shortage of individual therapies available**
  
- 13. Some patients were unaware of their rights**
  
- 14. All visits had to take place in the dining room**
  
- 15. A number of patients complained that the food was cold**
  
- 16. A number of patients complained about the prices in the outside shop.**

### **RECOMMENDATIONS-UNIT 3**

- 1. The problem of ensuring that the bedrooms have appropriate ventilation must be addressed.**
  
- 2. Patients should be given a choice whether they go out to the courtyard for smoke breaks.**

- 3. The courtyard facility should be redeveloped to ensure that the needs of the patient are met and that the environment has appropriate and safe facilities.**
- 4. The patients' issues with the use of the external shop should be addressed.**
- 5. The issue patients have that there is a threat of a move to Unit B if they become unwell should be addressed and any moves to a higher level of security should be determined primarily on an individual basis and should be determined by the risk posed by the individual patient.**
- 6. Patients should have access to more individual therapies on the unit.**
- 7. A system must be in place to ensure that all patients are aware of their rights pertaining to their detention.**
- 8. Patients' issues with the quality of food available should be addressed.**

**(Recommendations pertaining to this and other units are in the on Page 81)**

## **UNIT 4**

Unit 4, the Selective Adaptive Behavioural Unit (S.A.B.U.) opened in October 2005 and is situated on the ground floor within the main C.M.H. building. It is a 6-bedded unit which functions as a unit for service users with challenging behaviour and treatment resistant illness and who have required extended periods of observation and seclusion in other units. One of the key aims of setting up this unit was to reduce the levels of seclusion and prepare service users to move to a less secure environment.

The unit is an old ward but efforts have been made to brighten it. Each service user has their own room. The dining room is of sufficient size but quite bare. There is a large sitting room with plenty of chairs and a television. The toilets are open and there are bathing and showering facilities. There is also a visitors' room which is used in accordance with risk assessment of the individual service user. There is access to an outside garden. Staff complained of ongoing difficulties with electricity supply.

Referrals to the unit are from any unit in the C.M.H. excluding Unit A Female. All transfers are planned and referrals are discussed at a case conference following written referrals from the treating team. However as it is a ground floor unit, service users who have physical disabilities or are physically frail are also nursed in this unit from time to time.

## **SECLUSION**

Most service users who were transferred here had frequent and extended time in seclusion in other units. An audit of the rates of seclusion has shown that the amount of seclusion used for these service users has dropped significantly since the opening of the unit. There is one seclusion room in the unit. Staff stated that in six months since opening, there had only been six incidents of assault recorded. The view expressed was that this was due to the high staff to service users ratios, the precise care plans being developed and the close working between different members of the clinical team.

## **STAFFING**

In contrast to the rest of the C.M.H. one consultant psychiatrist has clinical responsibility for all service users on this unit. The unit is staffed on an alternating shift system as in the rest of the C.M.H. with nursing staff and care officers. There is a high staff service user ratio on this ward: there are five staff on duty during the day (8 a.m. to 9 p.m.) and 3 staff on duty at night. There are efforts to maintain continuity of staff. The NCHDs visit the unit daily.

## **SECURITY**

This is a locked unit but there is free movement around the unit. Each service user is locked in their room at night before 21.00 hours and there is no in room sanitation. The practice of slopping out ceased during the Inquiry process. Service users must now knock on the door of their room to get the staff's attention if they wish to use the toilet as there is no call bell as yet. Service users may access an outside area to smoke but only as a group.

There are seclusion facilities in the unit and protective clothing is always used. Subsequently the Senior Management Team have reported to the Inquiry Committee that the seclusion policy has been reviewed and the decision to use protective clothing is no longer automatic.

Staff in this unit are trained in RAID.

## **THERAPEUTIC ACTIVITIES**

There is a written daily programme for the unit and each service user is encouraged to attend activities such as the vocational programme, Wildwood, occupational therapy, and the garden projects. Service users are encouraged to look after their own hygiene and staff carry out activities of daily living with the service users. Clothes are washed on the unit by staff. However it was stated that it is hard to motivate service users to attend activities off the unit and occupational therapy time is also provided on the unit. There is a play station in the unit.

## **MULTIDISCIPLINARY TEAMS**

There is one multidisciplinary team with responsibility to this unit, unlike the rest of the C.M.H. where all teams have service users in all units. There is a weekly team meeting on the unit and staff reported that they feel as if they are part of the M.D.T. and contribute to case discussion. Staff report that having one team responsible for the unit is better both for unit management and clinical care of the service users. There is no keyworker system in operation.

## **CARE PLANS**

Service users have a nursing care plan and a T.C.P. The T.C.P.s are reviewed at case conferences every three months which are attended by the service user, carer, nursing staff and other multidisciplinary team members. The care plans were up to date and contained evaluations, reviews and progress notes. The care was planned with full M.D.T. involvement, especially from the psychology department, in ensuring the Behavioural Interventions Plans were clearly designed, implemented and evaluated. The service users are not involved in developing their nursing care plan and do not sign it. There was no keyworker system in operation which is surprising given the fact that behavioural interventions are more effective when there is a consistent approach applied (which a keyworker system would provide).

## **STAFF VIEWS**

The staff highlighted a number of issues during discussions with the Inquiry Committee.

### **High Staff to Patient Ratio**

Due to the specialist nature of the unit, there was an acknowledgement that the unit had a high staff to patient ratio in comparison with other units in the hospital with five staff on shift during the day. However, this was viewed as necessary as it was seen as this allowed the staff to focus on giving individual care to this group of patients. It also allowed the Behavioural Intervention Plan to be carried out.

### **Multidisciplinary Team Working**

There is one multidisciplinary team responsible for all the patients in the unit which staff on the unit feel facilitates the individual programmes, management and

functioning of the unit. Staff reported that they perceived themselves to be part of a team and that their contribution to the overall care of the patients was both valued and considered. There was also the view that this allowed a greater consistency of approach to be adopted which would affect all of the ward, rather than eliciting an approach that might only apply to one or two patients. It also ensured that staff knew who to contact and were aware of the rationale for decisions regarding care and enabled staff on the unit to feel that they were part of a team. Consequently, the relationship with the MDT was stronger with specific links between the ward staff and MDT members.

### **Planning of Ward**

Another positive view was the fact that ward staff were involved in the planning of the unit prior to it opening. This allowed staff, who were to be part of the ward team, to have a say in the design of the ward and the way in which the ward was to function. This was noted as indicating that staff views were being taken seriously when planning services

### **Seclusion**

Since the Unit opened in November 2005, the rates of seclusion have dropped dramatically (although we were unable to verify this as we were only provided with seclusion records up to November 2005). The staff stated that in these six months since opening, there had only been six incidents of assault recorded. The view expressed was that this was due to the high staff to patient ratios, the precise care plans being developed and the close working between different members of the clinical team.

### **Care Planning**

The care was planned with full MDT involvement, especially from the psychology department, in ensuring the Behavioural Interventions Plans were clearly designed, implemented and evaluated. There was no keyworker system in operation which is surprising given the fact that behavioural interventions are more effective when there is a consistent approach applied (which a keyworker system would provide). The ward staff also reported that they had a range of development opportunities including partaking in RAID training. The ward staff did not receive any supervision though

they stated there was close contact with other members of the MDT concerning clinical discussions.

### **Environment**

The main drawback identified by the ward staff was the poor state of the ward. The ward looked shabby and there were often problems with the electricity supply which would result in no power for the ward.

### **FINDINGS-UNIT 4**

- 1. The aim of reducing the amount of seclusion appears to have been achieved. The inquiry committee however were unable to verify this as it has only received the records of seclusion up to November 2005 despite requesting more up to date information. From discussions with unit based staff and patients on the unit it appears that levels of disturbance had dropped dramatically**
- 2. The inquiry committee found that there is a high ratio of staff to patients which enables individual programmes to be carried out and facilitates the Behavioural Intervention Plan**
- 3. The inquiry committee found that there is one multidisciplinary team responsible for all patients in the unit. This facilitates individual programmes, management and functioning of the unit. It enables staff on the unit to feel that they are part of a team and allows one point of referral and team discussion.**
- 4. There was no keyworker system in the unit**
- 5. The unit was not self staffing**
- 6. There is a rehabilitation focus in the unit with the stated aim of moving patients to less restrictive environments when appropriate. However patients with physical disabilities are transferred to the unit**

**solely because it is on the ground floor and has higher staff to patient ratios**

**7. Each patient has an individual behaviour programme with input from unit staff and psychology. All staff are trained in RAID. It was obvious that all staff interviewed were very positive about the function of this unit**

**8. Unit based staff were involved in the planning of this unit**

**9. The physical environment needed some attention**

#### **RECOMMENDATIONS-UNIT 4**

**1. All essential maintenance work should be carried out and a regular maintenance programme in place.**

**(Recommendations pertaining to this and other units are in the overall recommendations on Page 81)**



## UNIT 7

Unit 7 is an open rehabilitation unit for 14 men. The unit accepts service users usually from the hostel and Unit 3.

The staffing profile of the unit describes appropriate levels of staff to provide relational therapeutic security (3 members of staff by day and 2 at night). Each of the five consultant-led M.D.T.s has access to beds on the unit.

The stated objectives of the unit are

- To set achievable goals at the start of the period on the unit and review these weekly at M.D.T. meetings held on the ward.
- Involve the service user in the process of agreeing motivational goals and behavioural goals.
- To ensure the safety of all service users.
- Administering, for each service user a holistic, bio-psycho-social assessment of their psychiatric history and high risk and challenging behaviours to inform their treatment and care plans and therapeutic interventions.
- Develop a treatment and care plan for the service user which promotes positive mental health choices and minimises negative maladaptive challenging behaviours.
- Collaborate with the service user in the development of a treatment and care plan and a daily activity structure
- To enhance treatment and rehabilitation opportunities.
- To facilitate onward movement towards less intensive and less restrictive environments, usually within the community, within a foreseeable time scale.

The environment check highlighted that the practice of “slopping out” had ceased. However the service users interviewed stated that access to the toilet at night was a problem as they were locked in their rooms and had to call staff to let them out. The bedrooms are small and were described as cold especially in winter. There was a day

room and dining area and a small kitchen. The kitchen is in need of modernising. The service users have access to the kitchen at set times to prepare meals. There are bathrooms and toilets, which were described, as accessible.

### **MULTIDISCIPLINARY TEAM**

The staff reported that some of the M.D.T. meetings occur on the unit and others are held in the C.M.H. boardroom. It was stated that unit based staff have limited input to these meetings and decisions are made in their absence. The service user does not attend the meeting but is seen on the unit by their Consultant psychiatrist, registrar and social worker. The M.D.T. undertakes the risk assessments without the involvement of unit-based staff.

### **CARE PLAN**

The service users have separate nursing care plans with daily progress notes. There is no recognised keyworker system. There are case conferences held periodically. These are held in the boardroom and there is input from staff, family and the service user attends.

### **THERAPEUTIC PROGRAMME**

The service users attend activities off the unit and some attend Ushers Island. A community group has recently been started on the unit.

### **RISK MANAGEMENT**

Although each service user should have an individualised risk assessment there appears to be general policies regarding security i.e. all service users are locked in their rooms at night and no service user has unescorted leave in the grounds of the C.M.H.. If a service users' mental state deteriorates they are transferred to Unit B.

### **SERVICE USER VIEWS**

The service users on the unit raised a number of issues to the Inquiry Committee. Concerns were expressed regarding the food, stating that the portions were not enough and also the quality of the food. Service users can cook meals on the unit at weekends but it was reported that the kitchen on the unit was in need of updating and was unhygienic.

Complaints were expressed regarding the temperature in the unit especially in winter when the rooms are described as freezing with draughts blowing in through gaps in the windows.

Time off the unit was an issue the service users stating they were frustrated that they could not access the grounds unaccompanied and that they would value more frequent access to the gym and swimming pool.

Although slopping out had ceased, service users are still locked in their rooms at night and access to a toilet was problematic totally dependent on staff availability to open their bedroom door.

It appeared from discussions with the service users that they were often unaware of their legal status and their rights although the Inquiry Committee accepts that work has been done on this area.

#### **STAFF COMMENTS**

The staff interviewed viewed the unit as a low secure rehabilitation ward with most of the patients on the ward participating in rehabilitation activities during the day. They also stated that they viewed the majority of patients as primarily requiring rehabilitation and needed minimal security. Three staff were on shift during the day and three at night. Of the fourteen patients on the ward, six had unaccompanied parole. There was also the view that the ward was generally relaxed and there was a good relationship between staff and patients and this seemed to be the case during the inquiry visit to the ward. The staff also commented upon the following issues.

#### **Rehabilitation**

Most of the rehabilitation programme was accessed through therapeutic programmes (such as Industrial Therapy, GROW, Wildwood) Group meetings were held in the ward. Patients were locked in at night though the staff thought that only one or two patients would require that amount of security at night.

### **Care Planning**

It was stated that the ward had an “eclectic” model of care with no specific model being used to plan, undertake and evaluate care. There was a nursing care plan that was evaluated each week though there was no patient involvement in the development of this plan. Patients did not have a copy of their care plans. There was minimal ward staff involvement in the TCP with the patient also not having a copy of this care plan. Staff also commented about the fact that a major difficulty in establishing a keyworking system was due to a lack of staff continuity. They declared that the policy of central rostering resulted in staff members being moved frequently.

### **Personal development**

The staff maintained that there was a good staff development programme on offer. They stated that the service was good at encouraging staff to undertake courses and there was general agreement that there were a good range of courses to choose from. However, none of the staff had received any clinical supervision regarding their practice nor had any appraisal of their work.

If a patient relapsed the staff stated that the MDT would be informed and it was usually the case that a patient would be transferred to Unit 2 or 3 which were geared towards higher levels of security and could observe the patient more closely. Their place on the ward was only kept for one week however and then the patient had not returned to the ward, they would then have to work their way “through the stamp”. This was viewed as a powerful disincentive for patients and meant that individual who may have been unwell for a brief period would lose their place on the ward.

### **Environment**

The staff stated that the ward needed some repairs to it. There was no privacy for the patients in the shower area which was not viewed as beneficial to the patients. There was also the view that there were minimal facilities on offer on the ward for patients to undertake ADL or therapeutic activities.

### **Communication**

There were a number of comments made about the lack communication between ward staff and other members of the team. A number of examples were given including having no discussion regarding the potential of moving to a new unit, having little

contact with members of the Senior management team and that the MDT members isolated themselves and made decisions without consulting ward staff.

#### **FINDINGS-UNIT 7**

- 1. The uniform locking of bedroom doors at night is unacceptable**
- 2. Although the practice of slopping out had ceased, patients now had to bang on their bedroom door to be taken to the toilet**
- 3. Unit based staff felt under represented in the multidisciplinary teams and undervalued at team meetings and case conferences.**
- 4. The venues for team meetings varied between the unit and the conference room**
- 5. There was no keyworker system in the unit and no model of care.**
- 6. The unit was not self staffing**
- 7. There was little access to the grounds for the patients. Quite often there were insufficient staff to escort the patients**
- 8. No patients are considered for unescorted parole in the grounds**
- 9. Many patients had little knowledge of their care plan and some stated that they did not have a copy of their care plan**
- 10. Some patients were unaware of their rights**
- 11. A number of patients felt that there was a threat of being moved to Unit B if they became unwell**

**12. There was a lack of information available to staff on the unit from the management team on issues pertaining to audit and service development**

**13. The physical environment needed some attention**

**14. Five multidisciplinary teams have access to the beds on this unit**

**15. All visits had to take place in the dining room**

**16. A number of patients complained that the food was cold and insufficient amounts**

#### **RECOMMENDATIONS-UNIT 7**

- 1. The issue patients have that there is a threat of a move to Unit B if they become unwell should be addressed and any moves to a higher level of security should be determined primarily on an individual basis and should be determined by the risk posed by the individual patient.**
- 2. A system must be in place to ensure that all patients are aware of their rights pertaining to their detention.**
- 3. Patients' issues with the quality of food available should be addressed.**
- 4. There should be a clear system of communication between the Senior Management Team and the units' staff.**
- 5. All essential maintenance work should be carried out and a regular maintenance programme in place.**
- 6. There should be sufficient staffing resources to ensure that the patients have their escorted parole in the grounds of the CMH.**

**(Recommendations pertaining to this and other units are in the overall recommendations on Page 81)**

## **HOSTEL WARD**

### **DESCRIPTION**

The hostel is located on the grounds of the Central Mental Hospital and is part of the hospital complex. It is a two storey house that was formerly a staff house and functions as a rehabilitation hostel. It is a 10 bedded facility and during our visits there were 10 residents in the house.

The hostel resembles a domestic residence with a functioning kitchen to which the patients have access. There is a dining room and the residents eat all meals in the hostel unless they are off site. The sitting room is comfortable and spacious and residents relax here in the evening. There are eight bedrooms upstairs and a bathroom, shower and toilet. There is an office for staff downstairs. Residents have input into the decoration of their bedrooms and choose their own colours. While the hostel is reasonably well maintained the staff complained about the poor availability of maintenance. There was also some concern expressed at the limited kitchen facilities available for the ten residents.

Residents are transferred to the hostel from the main hospital building. Usually residents progress through high and medium secure units before progressing to Unit 7 which is termed a low secure unit. From Unit 7 they are transferred to the Hostel when well enough and when there is a bed available. Should residents become unwell once in the hostel, they are transferred back to the admission unit or to Unit 2 or 3 which are medium secure units. As their beds are not reserved for them in the hostel it is usual for them to once again progress through the system and wait for a bed to become available in the hostel, even if their relapse is of short duration. Residents spoke about this in detail and stated that all efforts are made not to communicate any deterioration in their own well being due to their fear of having to return to Unit B and have to work their way through the system again. In response to these concerns, the senior management team have pointed out that they were unaware of any instance within the past few years of a patient returning to Unit B although acknowledged that if someone was becoming unwell, a patient would be transferred to either Unit 3 or Unit 7 where there were higher staffing numbers.



## **SECURITY**

The hostel is open and the residents are free to go around the grounds of the hospital. Residents may be on Guilty but Insane status or under section 208 of the Mental Treatment Act, 1945. There is no seclusion in the hostel and residents are not locked in their rooms at night.

## **ACTIVITIES**

Some residents attend the centre in Usher's Island as part of their rehabilitation. Others attend the activities in the grounds of the hospital. Some patients are allowed to leave the hospital grounds and some may have home leave. No resident is self-medicating or on a self-medicating programme. Most rehabilitation programmes are through the occupational therapy in Usher's Island and the VEC projects. It was felt by staff that all 10 residents are now ready for supervised residences in the community

## **STAFFING**

The unit is staffed in the same way as the remainder of the hospital; there is an alternating shift system between care officer staff and nursing staff. The staff were not permanently placed onto the unit and there was the view that staff could be moved (and were moved) without notice. Overtime was also used to staff the unit. There is one staff on duty during the day and one at night. During both shifts staff in the hostel may be called away to provide escorts, relief and other duties. Patients complained that recently there has been lack of continuity of staff in the recent months. At the time of reporting the staff nurse on duty during the day was 'acting up' to CNM 2. This nurse could be moved to another unit at any time, making it difficult to manage the unit and engage with residents. The staff report to the ADON who visits the unit twice a day.

## **MULTIDISCIPLINARY TEAM**

All multidisciplinary teams have clinical responsibility for residents in the hostel. Some multidisciplinary team meetings are held in the unit and some in the Boardroom in the main building. The meetings in the Boardroom are difficult for staff from the

unit to attend. The social workers attend the hostel and meet with residents. There is no key worker system within the multidisciplinary team.

## **USER VIEWS**

The general view of the service users was that when staff that had experience of the hostel were on duty, that are on that know the place, things are good with relations between the staff and patients being viewed as positive. However, consistency of staff could be a problem with staff being placed on the unit (during days off or holidays of the more regular staff group) that did not have experience of the workings of the hostel and did not have much contact with the residents. One problem that was given as an example was that these staff would sit next to the patients when they were on the phone whereas the normal staff did not do this. As noted above, there were often no staff on the unit at times during the day and night as they are taken from the hostel and placed elsewhere primarily to cover staff breaks on other wards. The placing of staff elsewhere causes some problems with medication sometimes being late and phone calls missed. There were also some concerns expressed by the fact that contact with members of the SMT was limited although the fact that many were off the ward for the majority of the day would undoubtedly have had an effect on this. An example given was that one service user had asked for the phone to be enabled to have incoming calls allowed in the unit and approached staff about this. The request was turned down by the SMT though no reason was then given to the patient or the refusal. The patients were still uncertain with regards the reasons for this. The inquiry team have subsequently learned that the Senior Management Team had agreed to this request. But there were problems in implementing the decision. It does suggest that a lack of clear communication leads to information not being relayed to the patients and for the patients to be left to make their own assumptions.

It was noted by the service users that there was usually only three patients on the ward for most of the time during the week.

In relation to the discussion about care, some of the patients had a copy of their TCP but not all. A number attended their ward rounds though those with outside engagements often did not as they preferred not to come back to the hostel. All the patients stated that they considered that there was no real discussion in the ward round and all the decisions had been decided beforehand. However, it was acknowledged

that they were able to discuss their care with the ward staff and to make requests to their care team via the ward staff.

They all stated that they attended their case conferences although, once again, there was the assumption that decision had already been made beforehand and that they had only a limited involvement in any discussions. They had no access to their notes and were not aware of what is being written down about them of their care.

Visits were held in the ward while any family visits, which included children, were held in the Seomra.

### **Legal Restraints**

The patients specifically raised concerns about the problems of those patients admitted under GBI. These problems centred on the following areas:

- a) They had to wait until the last minute to get parole for visits outside the hospital.
- b) Although they were aware that the Consultant Psychiatrist was in charge of their care and treatment, they were unsure who was responsible for arranging their discharge and how this was to be obtained.
- c) There was a perceived lack of support for “putting things in place” prior to discharge.

There was general concern that if people “pushed” for answers they were perceived as rushing their care and there was a view that this might lead to the resident being viewed as difficult or unwell. This could then lead to restrictions being put in place such as a transfer back to Unit B. There was an acknowledgement from ward staff that there were problems with the legal system which severely restricted the ability of the service to get patient out of the Hospital. It was stated that permission to allow leave was often granted by the Department of Justice at the last moment and this led to difficulties in the amount of forward planning that could be undertaken.

In relation to the view that patients would be perceived as difficult if they disagreed with MDT decisions, a similar view was expressed about medication with limited discussion taking place between staff and residents about the need for medication or the effect of medication. Again, the comments were that if people were prescribed medication they had to accept it as, if not, they would be sent back to the admission ward (and would then have to work themselves through the system to get back to the hostel). This then might take years. This was indicative of what was seen as pressure to conform. If not then there would be serious consequences.

There was also concern expressed about the fact that the gratuity for a person on GBI was less than patients on other orders. A social worker had taken up the case but had not come back and told them of the result of any inquiries.

### **STAFF VIEWS**

The ward staff were clear in their view that all of the patients have the ability to live outside in the community. Most are able to cook but are unable to do so in the hostel though this was primarily due to the inadequate kitchen facilities available. The inquiry has since been informed that the kitchen facilities in the hostel are to be upgraded.

The hostel staff stated that there was some interaction with the MDT and that there were able to attend most MDT meetings with some held in the hostel and some in boardroom. The SMT came on a periodic basis to visit the hostel but it was difficult to meet most of the patients as most were out of the Hostel during the day. Staff also noted that if they complained about the service, there was a likelihood of being moved without warning to another ward. This was viewed as being as a way of ensuring that staff did not voice concerns about the service. The ward staff viewed as positive the increased number of courses on offer for staff to attend though also noted that there were problems with being able to attend some courses due to staffing problems.

### **FINDINGS-HOSTEL WARD**

- 1. The inquiry committee found that there was a perception among patients that they would be transferred to restrictive units if they reported any deterioration in their mental health or made complaints. The patients thought that if someone returned to another unit then their place in the hostel would be lost although senior management stated that this was not necessarily the case. The inquiry committee was concerned that feeling unable to report symptoms or raise complaints meant that patients mental well being was at risk as well as the ability to build a relationship with their treating team and unit based staff**

- 2. The inquiry committee found that the openness and homeliness of the Hostel Ward was conducive to rehabilitation. However the lack of use of the kitchen for patients causes concern.**
- 3. The inquiry committee found that the inconsistency of staffing in the hostel ward was extreme and interfered with ongoing rehabilitation programmes**
- 4. There was no keyworker system in the unit and no model of care.**
- 5. The unit was not self staffing**
- 6. The physical environment needed some attention**
- 7. Five multidisciplinary teams have access to the beds on this unit**
- 8. Many patients had little knowledge of their care plan and some stated that they did not have a copy of their care plan**
- 9. Patients were being supervised when using the telephone**
- 10. It was reported that all 10 patients in the hostel ward could move on to community placements**
- 11. Some nursing staff reported that they were afraid to flag problems as it may effect their career prospects within the CMH**

#### **RECOMMENDATIONS-HOSTEL WARD**

- 1. Alternative accommodation should be sourced in conjunction with the HSE for the patients in the Hostel Wards if they no longer require the facilities of a secure hospital.**

- 2. The issue patients have that there is a threat of a move to Unit B if they become unwell should be addressed and any moves to a higher level of security should be determined primarily on an individual basis and should be determined by the risk posed by the individual patient.**
- 3. Patients should not be supervised on the telephone.**
- 4. All essential maintenance work should be carried out and a regular maintenance programme in place.**
- 5. There should be a clear system of communication between the Senior Management Team and the units' staff.**

**(Recommendations pertaining to this and other units are in the overall recommendations on Page 81)**

## OVERALL RECOMMENDATIONS FOR UNITS

The following recommendations arise from the findings from a number of units:

- 1. With the exception of Unit 4 all 5 multidisciplinary teams have access to beds in all units. Consideration should be given to replicate the approach to service delivery in Unit 4 which has a dedicated MDT providing care in which nursing staff feel involved.**
- 2. All units in the CMH should be self staffing to ensure continuity of care and to enhance the unit based staff' role and responsibilities within the MDT.**
- 3. With the development of multidisciplinary care plans a keyworker system should be introduced ensuring that each patient has a keyworker from the most appropriate profession.**
- 4. All patients should be involved in their care plan and should receive a copy.**
- 5. Apart from the Hostel Ward no patient has unescorted parole in the grounds of the CMH. A system should be introduced to give patients unescorted parole in the grounds determined primarily on an individual basis and determined by the risk posed by the individual patient.**
- 6. A consistent model of care should be implemented on all units.**
- 7. The venues for team meetings should be consistent amongst all teams ensuring that all disciplines can attend and contribute to the care process.**
- 8. The locking of bedrooms should be determined primarily on an individual basis and should be determined by the risk posed by the individual patient.**

- 9. Those patients who have their bedrooms locked should have call buttons in their rooms to be able to communicate with staff when they require assistance.**
  
- 10. Any contract with cleaning services should ensure that high standards of hygiene and cleanliness are met at all times.**
  
- 11. All staff should have access to clinical supervision.**



## SECTION 6 - SECLUSION

### **Overview of Seclusion Policy**

The guidelines concerning the use of seclusion are contained in the seclusion policy dated August 2002 and was last formally reviewed in September 2004. The main elements of the policy are; to define seclusion, its role in the care and treatment of patients in the Central Mental Hospital, the use of seclusion, how seclusion is reviewed, observation of patients in seclusion (including guidelines as to the condition of the seclusion room), and how seclusion is audited, (including patient review and data and practice review). It interlinks with the policies concerning time out and patient observation.

Within the policy, the definition of seclusion recorded in the Mental Treatment Act 1961 is used. Seclusion is defined as the placing of a patient (except during the hours fixed generally for the patients in the institutions to retire for sleep) in any room alone and with the door locked or fastened or held in such way as to prevent the egress of the patient. The policy also notes that seclusion is a prescribed therapeutic intervention forming a broader approach to the management of aggression and violence. In addition, it should always part of a larger treatment plan which includes interventions such as de-escalation, control and restraint and prescribed medication. The hours of seclusion within the Central Mental Hospital are defined as between 8 am and 9 pm while other times when a patient is placed in a locked room is not categorised as seclusion. It was reported by the Clinical Director that this definition is used throughout most of the country. Seclusion could be initiated by any staff member but must be medically prescribed and would need to be reviewed by a Doctor as soon as practically possible if not initiated by a Doctor. It is stated that seclusion should only be used when all other interventions approaches have failed, should be for as short a period as possible, that fifteen minute observations are recorded and that a special observation book should record the patient's mental state and activity at each fifteen minute check. In addition, two staff should physically enter the room every two hours to check on the patient and a Consultant Psychiatrist should check on the patient every twenty-four hours.

### **The Use of Seclusion**

The use of seclusion in the Central Mental Hospital was examined through consulting a range of sources of evidence. These were:

- Clinical Risk Management Policy (August 2005)
- Policy on the Prevention and Management of Violence and Aggression (March 2004)
- Central Mental Hospital Seclusion Policy (August 2002)
- Policy on Time Out at the Central Mental Hospital
- Incident Reports (January 2004 to November 2004)
- Audit of Incident Forms (January 2005 – November 2005)
- Risk Management Committee Meeting Minutes (July 2005 – October 2005)
- Clinical Governance Questionnaire
- Full Assessment of Risk Form
- Seclusion Records
- Random Selection of Patient Case Notes (MDT notes and Ward notes) from each unit.
- Audit of seclusion (January-October 2006)
- Interviews with Staff Members
- Interviews with Patients
- Interviews with Carers

### **Recording of Episodes of Seclusion**

The inquiry team carried out an inspection of a random selection of seclusion records. This inspection indicated that each seclusion initiated had been recorded on the relevant forms and that reviews of seclusion were carried out in accordance with the prescribed policy.

### **Audit of Seclusion**

The policy document indicated that as part of the audit process, an evaluation of the effectiveness of seclusion should be completed when the decision is taken to discontinue seclusion and that this must be in the patient's cases notes. We were unable to find neither any evaluations in the patients' case notes that were examined nor any formal evaluation of the efficacy of seclusion. It was also acknowledged by



makes the actual total number hours of seclusion even longer. In addition, some of the data in the 2006 seclusion figures were missing meaning the true level of seclusion is higher. It is acknowledged that the Central Mental Hospital deals with the most severely unwell and most dangerous patients in the Irish mental health service. It is, therefore, the case that a number of patients would require seclusion during the course of their care and treatment. It is helpful to examine the rates of seclusion in the Central Mental Hospital with a comparative service. The rates of seclusion within the UK can act as a comparative measure though it is acknowledged that there are differences in the services and so cannot be viewed as identical. A comparison can be made from the data examining the number of seclusion hours per secure bed that were calculated for the seven different medium secure units in London in 2006 (Table 6-1). The Table shows that the amount of seclusion ranges from 0.83 hours to 12.44 hours of seclusion per secure bed. The comparative figures for the Central Mental Hospital in 2006 show a yearly equivalent rate of 91.51 hours of seclusion per secure bed. It should be noted that the seclusion rates from a UK Special Hospital for the same period showed that on there were average 201 hours of seclusion per seclusion bed and is similar to the amount of seclusion in the Central Mental Hospital (as night time seclusion is recorded in these UK figures). The number of patients admitted to the Central Mental Hospital requiring high security care is acknowledged by the staff of the service to be very small. Therefore, to have comparable seclusion rates to a UK Special Hospital also supports the view that the rates of seclusion are high.

Table 6-1 – Episodes of Seclusion in London Medium Secure Units

<b>Unit</b>	<b>No. of episodes</b>	<b>Average length of each episode (hrs)</b>	<b>No. of patients</b>	<b>Total hrs seclusion</b>	<b>No of secure beds</b>	<b>Hrs seclusion/secure bed</b>	<b>Ratio of numbers of pts secluded/total no secure beds</b>
<b>Unit A</b>	88	24.75	46	2178	175	12.44	1: 3.8
<b>Unit B</b>	21	29	14	609	132	4.61	1: 9.4
<b>Unit C</b>	9	3.75	8	33.75	69	0.48	1: 8.6
<b>Unit D</b>	18	15	11	270	29	9.31	1: 2.6
<b>Unit E</b>	47	1.75	7	82.25	60	1.37	1: 8.5
<b>Unit F</b>	17	7	6 (1 of whom was secluded 8 times)	119	74	1.61	1:12.3
<b>Unit G</b>	116	14	47	1624	214	7.58	1: 4.5

The figures for the first ten months of 2006 show a marked improvement. The opening of Unit B and Unit 4 were both seen by the service as contributory factors. However, the level of seclusion is still high. The reasons for this amount of seclusion are difficult to establish. However, certain reasons were put forward during the course of the inquiry and these are now considered.

**Prison Admissions**

The service operates a service to provide admission from a number of prisons from the Dublin area and the midland area of the country. It is acknowledged that the Central Mental Hospital provides a valuable service to prisons and admits many patients from prisons who have mental health problems. One of the effects of these prison transfers is that a number of patients admitted to the admission wards are

acutely unwell and are treated at the Central Mental Hospital with the intention of then returning to the prison from where they were admitted. This results in many of the initial admissions requiring care similar to that within a Psychiatric Intensive Care Service. It is also the case that newly admitted patients often have periods of behavioural disturbance while a treatment regime is being established which necessitates short periods of seclusion to manage this behavioural disturbance. It is worth pointing out that these patients should not be considered as needing high secure services though it is acknowledged that they would cause management difficulties on the ward until their mental health difficulties are able to be effectively managed.

**No consideration of alternatives to seclusion**

The seclusion policy states that it would only be used as a last resort and when all other interventions have failed. Some ward staff reported that seclusion was only used as a last resort when the patient is viewed as a high risk towards others due to being acutely psychotic, or when they were deemed as being a harm to themselves. However, other ward staff stated that seclusion would be the only consideration when debating an intervention and it would be the automatic response if any violent act (or the potential for a violent act) had occurred or when there were concerns about the potential for dangerous behaviour. In addition, the patient case notes often do not document any discussion surrounding other options, with the possible exception of a review of medication, rather than seclusion. One set of patient case notes stated that if a patient requested seclusion as he “felt like cutting himself” the request would be agreed and this person placed in seclusion. No alternative intervention was discussed within the plan of care documented in the notes.

A number of ward staff commented that “specialing” (comparable to level three observations) of patients as opposed to seclusion was rarely used and we found little evidence of this intervention as an alternative to seclusion. Likewise, alternatives such as engaging with patients on a one to one basis, the use of distraction techniques, or relaxation, were not viewed as a treatment option. The experience of using non-medical alternatives to seclusion such as the RAID training approach used in Unit 4 seemed to show the potential value of alternative approaches but there was little evidence in other areas.

### **Patients admitted to seclusion wards being initially secluded for the first day or two following admission**

There was some evidence to suggest that when people were admitted to the admission wards, they were routinely secluded. The inspection of case notes supported this view. The majority of carers stated that most new admissions were placed in seclusion for the first twenty-four hours as a matter of course. There was support for this view by many patients who were secluded for one to two days following admission. They also reported that they did not remember being given any reason for their seclusion. It was acknowledged by many senior clinicians at the Central Mental Hospital such as the Clinical Director and the Director of Nursing, and by some ward staff that this may have been common practice at the early stages of the time period of this inquiry (up to early 2005) but that this practice had stopped and that seclusion was now only considered as a last resort. However, other senior members of the clinical team, such as the Head of Psychology and Head of Social Work, as well as several members of the ward staff reported that they viewed that the level of seclusion remained too high and there was still a likelihood of over-seclusion in the admission wards. In our examination of patient case notes, the majority of patients had been secluded upon admission. In addition, there were some case notes that contained no information for the reason for seclusion and one patient whose case notes (ward notes and MDT notes) contained no description that the patient had been secluded although this was recorded in the seclusion book. The first indication that the patient was in seclusion only occurred the following morning when it was documented that the patient was assessed in the seclusion room. The service have stated that it was not their policy to automatically seclude patients and informed the inquiry that a recent audit of current practice had indicated that, since January 2006, fifteen out of twenty eight male admissions required seclusion upon admission.<sup>3</sup>

### **Intermittent Seclusion**

It was noticeable when reviewing the seclusion records and the case notes that patients were sometimes secluded for certain periods of time and then allowed out of seclusion for periods before being secluded again (i.e. secluded between 8 am to 1pm

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<sup>3</sup> The CMH have subsequently indicated that 2006 figures showed one third of admissions were secluded around the time of admission. The inquiry was unable to examine this claim, as this would require having access to individual patient admission and seclusion records.

and then between 6pm and 9pm (when it no longer is officially seclusion). It was noted that some case notes contained the comment that the patient “requires intermittent seclusion” which appears to endorse this view. Comments from a number of ward staff suggest that this is a common practice to let people out when there were sufficient staff within the unit.

### **Seclusion being used as a punishment**

In the meeting with carers, some of the group suggested that seclusion had been used as a punishment by staff. The inquiry found no supportive evidence for this argument with none of the patients interviewed perceiving that staff used seclusion in this way. In addition, several members of the clinical team and members of the ward staff stated that seclusion was not used as a punishment. Finally, the reports in the patient notes did not identify nor suggest that any seclusion had been initiated as a means of retribution.

### **Training**

#### RAID® training

It was reported by the Head Psychologist about the development of RAID® may have a positive impact on the development of developing alternative approaches to seclusion. The training is a three day course delivered by a division of the Association for Psychological Therapies (APT) and is focused on developing consistent and positive interventions for difficult behaviours. At the time of the meeting with the Head Psychologist in March 2006, thirty-two members of staff had attended the course including all staff on Ward A and Unit 4. The patients currently residing in Unit 4 had accounted for a large number (and time) of seclusions in Unit 1. However, it was reported there have been minimal periods of seclusion since they had been transferred to Unit 4 and only three assaults in the previous three months prior to our visit to the Unit. The effects of having one clearly defined clinical team for the entire ward, the additional amount of space with only five patients in one unit, and the high staff to patient ratio were also viewed as contributory factors in reducing seclusion. However, the effect of RAID® on the ability of staff to deal with difficult behaviours was acknowledged by the ward staff and the Head of Psychology. They gave an example that when patients previously requested time out, this would require staff to formally seclude the person. However, recent developments had seen a different



response that had been to discourage the use of time out and to encourage the patient to go into the day room and work through their problem. The patients in Unit 4 who talked about being less disturbed and less likely to exhibit difficult or destructive behaviours also recognized the benefits of this approach. The rates of seclusion recorded in the first ten months of 2006 seem to support these considerations.

### **Prevention and Management of Violence and Aggression**

The ward staff attend a five day course which includes learning about different responses to violence and aggression with particular emphasis on de-escalation techniques and control and restraint techniques. A number of ward staff found this to be helpful to them in dealing with violent incidents. There is some evidence to suggest that ward staff use de-escalation techniques when dealing with some untoward incidents though there is a limited amount of information as to how this is implemented. Although there were some isolated reports that control and restraint had been used inappropriately, the vast majority of respondents did not view the use of this measure as problematic. However, there were few incident reports documenting the use of control and restraint which is part of the reporting of untoward incidents. Part of the Prevention and Management of Violence and Aggression policy states that when control and restraint had been used, Prevention and Management of Violence and Aggression (PMVA) forms should be filled and there by a formal review of the incident that had taken place. When examining reports of incidents where control and restraint had been used, the inquiry could find no evidence of these responses being undertaken.

### **Other Issues Surrounding Seclusion**

#### **Concerns about male staff being involved in the seclusion of women**

There were a number of reports from carers, patients and ward staff that male staff were sometimes involved in the seclusion of female patients on Unit A though the actual proportion of time that male staff were involved was unclear. This included forcibly removing the patients clothing and placing the patient in refractory clothing. The effect of this on women was that they felt uncomfortable and exposed when this was taking place. The seclusion policy states that if possible staff of the same sex as the patient should carry out the procedure and that if male staff were involved in the

secluding of a female patient that a female staff member should remain in the room. There were a number of ward staff who commented that male staff were often used to seclude female patients as they were stronger and could initiate the procedure more effectively. Female patients also commented about the fact that they were often left with no underwear when placed in seclusion. The senior management team were concerned about any actions that could be degrading for female patients and during the course of the inquiry ensured that female patients should have access to paper underwear to wear during seclusion. (This is commented upon in the report on Unit A in Section 4 of the report).

### **Recording of reasons for seclusion and information**

The seclusion policy indicates that the register of seclusion book must clearly state the reasons for seclusion and that the patient's mental state and activity be recorded at least every fifteen minutes in the special observation book. The reasons for seclusion as recorded in the seclusion book vary and are sometimes not clearly detailed but focus on more general depictions such as the patient was disturbed. The Assistant Directors of Nursing stated that the main nursing role was centred around ensuring that the patients physical functioning was satisfactory and to work around the patients anxiety concerning seclusion.

### **Protective Clothing**

A number of carers expressed unhappiness at patients being placed in refractory clothing prior when being placed in seclusion. The policy documents states that refractory clothing and rugs shall be standard for any patient in seclusion and also standard at night for any patient on level two observations. The reasons for the removal of clothing does seem to be undertaken as a matter of course and does not seem to be based on any clear individual assessment of risk and needs of the individual patient. Since the visit to the Hospital, we have been informed that the service has amended its policy. The terminology used is no longer refractory clothing, with the term protective clothing now preferred. In addition, the use of protective clothing and bedding is no longer automatically used when a patient is in seclusion with its use based on an individual risk assessment.

### **Observations**

The seclusion policy states that patients in seclusion are only observed every fifteen minutes unless prescribed to be on continuous observations. This practice was in operation when the inquiry team visited the wards during the course of the inquiry. However, there does not seem to be a system of assessment to record whether a patient in seclusion requires closer observations. One concern that was observed at first hand was that a patient with serious physical problems was being observed every fifteen minutes but there were no staff in the vicinity of the seclusion room area for the majority of this intervening period.

### **Time Out**

The use of time out is stated in the policy on Time Out at the Central Mental Hospital (2002). It is defined as a therapeutic process designed to allow a patient experiencing distress spend time away from the main body of the ward, with staff support. The patient could go to his/her room or to the seclusion room with a staff member in the near vicinity and level two observations (observing every fifteen minutes). However, only those patients who were considered settled and had gained a degree of trust from staff had the opportunity to have their door unlocked during this period. The patient, however, could request to come out of their room once feeling less distressed. We were informed that this practice had been discontinued following a directive from the Director of Nursing and that it was now the policy to record this period as seclusion.

### **FINDINGS - SECLUSION**

- 1. Amount of Seclusion. The evidence points to an excessive use of seclusion specifically within the two admission wards. This was supported by the seclusion records noting the number of episodes of seclusion and the total number of seclusion hours. This view was expressed by many staff and by patients and carers.**
- 2. Seclusion upon Admission. There was some evidence to support the view that it was a routine procedure for patients to be placed in seclusion upon admission.**

3. **Seclusion Documentation.** The documentation supporting the use of seclusion was variable with at times no clear rationale for the use of seclusion detailed.
4. **Recording of Patients Mental State During Seclusion.** There was often no recording of the patient mental state during periods in seclusion.
5. **Alternatives to Seclusion.** There appeared to be limited alternatives considered to seclusion although the recent introduction of the RAID training did seem to be viewed as a positive move and appeared to be reducing the use of seclusion in Unit 4.
6. **Audit of Seclusion.** There were no specific reviews by the MDT's to examine either the efficacy of seclusion for individual patients or any evaluation of the appropriateness of seclusion. Although an audit of seclusion was carried out, this focused on whether the documentation had been filled in and the amount of seclusion.
7. **Recording of Control and Restraint.** It appears that many incidents where control and restraint was used were not recorded, in the relevant case notes, nor the untoward incident form or on a Prevention and Management of Violence and Aggression form.
8. **Control and Restraint.** From those records that were reviewed by the Inquiry Committee it appears that the use of control and restraint is undertaken in a manner that was in keeping with current established practice.

#### **RECOMMENDATIONS- SECLUSION**

**Seclusion –** There are new regulations proposed by the Mental Health Commission that will form the basis of instigating and recording seclusion. It is, therefore, inappropriate to make any recommendations relating to this area. We are making a number of recommendations in additions to these proposals. These are:

1. **Alternatives to Seclusion.** We recommend that alternatives to seclusion are examined and that these are documented in the patients' care plans.

2. **Evaluation of alternatives to Seclusion.** In addition, to the previous recommendation, we suggest that there are regular evaluations of the efficacy of these alternative approaches to seclusion.
3. **Clinical Governance Committee.** We propose that a multidisciplinary clinical governance committee be established, which includes members of the ward staff team, meet on a three monthly basis to examine seclusion. The areas to be examined should include; the amount of seclusion used, the reasons for seclusion, the length of seclusion, alternatives to seclusion used, and an evaluation of the appropriateness of seclusion and the efficacy of any planned alternatives.
4. **Control and Restraint.** Many situations where control and restraint is used are not recorded in the relevant documentation. All episodes where control and restraint is used must be recorded. The policies surrounding the documentation of Control and Restraint should be reinforced and regularly audited. The proposed clinical governance committee would be an appropriate meeting for this to be reviewed.

**(Seclusion – As of the 1<sup>st</sup> of November 2006 there are new rules on Seclusion and Mechanical Means of Bodily Restraint issued by the Mental Health Commission that form the basis of instigating and recording seclusion).**

## SECTION 7 - RISK MANAGEMENT

Risk management issues are assessed and developed using a range of sources. The information contained within this section came from the following:

- Clinical Risk Management Policy (August 2005)
- Policies and Procedures for Notification of Serious and Untoward Incidents, Deaths, Resulting reviews and Inquiries (Revised draft 2004)
- Policy on Searching of hospital In-Patients (January 2000)
- Policy on the Prevention and Management of Violence and Aggression (March 2004)
- Central Mental Hospital Seclusion Policy (August 2002)
- Policy on Time Out at the Central Mental Hospital.
- Policy on Patient Observation
- Incident Reports (January 2004 to November 2004)
- Audit of Incident Forms (January 2005 – November 2005)
- Risk Management Committee Meeting Minutes (July 2005 – October 2005)
- Clinical Governance Questionnaire
- Full Assessment of Risk Form
- Seclusion Records
- Case Notes
- Audit of seclusion (January-November 2005)
- Interviews with Staff Members
- Interviews with Patients
- Interviews with Carers

### Overview

The Central Mental Hospital has a comprehensive policy with regards the assessment and management of risk that was implemented in August 2005. It was due for evaluation in August 2006. It is documented that the clinical risk management policy should be read in conjunction with all other Central Mental Hospital policies. The Clinical Risk Management policy concentrates on: risk assessment, risk management strategies, reporting and management of incidents including near misses and minor

incidents, and revising critical incidents. The clinical governance questionnaire also notes that the service provides risk assessment and risk management training to other agencies within Ireland. It also provides a specialist (tertiary) risk assessment and recommendations for risk management to community teams. There are also clear policies regarding the handling of medication, child protection and dealing with vulnerable adults.

The policy defines risk management as the process of measuring or assessing risk and developing strategies to manage that risk. It aims to ensure that all staff have adequate information on all types of assessment and management of risk that occur in the service as well as the procedures in place to assess and manage risk. The policy also states that it is the duty of all staff to ensure that care conforms to established standards of care and that staff and management have equal responsibility to ensure the staff have, and maintain, adequate training, knowledge and skills to do the job. It also states that patients must have the opportunity to be active participants in planning their care. This should be achieved through providing information to patients in a manner and form that enables them to make informed decisions and give consent regarding their treatment. In addition, the clinical governance responses reported that the Central Mental Hospital engaged in positive risk taking related to an individual assessment of need.

### **Risk Assessment**

The clinical risk management policy details that risks will be identified and recorded using the CMH risk assessment tool Treatment and Care Planning Form 2 (TCP2). The tool is used to identify all risks that may have a foreseeable impact on the patients and staff. It was also noted that risks would be evaluated using the risk management process and risk prioritisation scale. The Treatment and Care Planning Form (TCP) documents the multi-disciplinary team care plan and gives an overview of the current risk posed by the individual patient. This is updated at the time of each patient's case conference. As part of the TCP a full assessment of risk form is also undertaken and discussed as part of the conference. The inquiry team examined a number of current TCP forms and risk assessment forms. The assessment form clearly identifies previous risk factors, current risk factors, the views of the patient and carer regarding risk, as well as an assessment as to the potential harm posed by the risk. The

assessment of risk appears to be extremely thorough with the completed forms constructing a focused examination of past, present and future risk. However, one limitation was the minimal amount of risk management planning that was documented to target and develop the care of the patient. The proposed risk management strategy that was viewed primarily consisted of medication management, further assessments, as well as the need to use seclusion when required. The inclusion of the full risk assessment form as part of the risk assessment strategy seems to have been a relatively recent occurrence with evidence from case conference records that this assessment was not completed for a number of case conferences undertaken prior to January 2006. There was also an assumption from the clinical governance questionnaire that as far as possible attempts would be made to involve the service users in this plan. In discussions with patients and carers the majority reported that they had minimal or no discussions with staff members regarding their risk assessment. Several patients also reported that they had not been informed of their assessment of risk. Finally, there was also evidence from both staff interviews and from the ward case notes that the ward staff were not involved in this risk assessment procedure. Some ward staff reported that they would give some informal input to a case conference in relation to the assessment of risk but there was no formal mechanism for this to occur. Additionally, some ward staff did not have access to these risk assessments and were unaware of the findings of the risk assessments.

### **Risk Management**

The clinical risk management policy states that a risk assessment is regularly carried out on all patients and is regularly documented, disseminated and reviewed. The risk assessment and management should also include an evaluation of the risk arising from a particular problem as well as deciding on the measures to eliminate or reduce the risks. It also notes that good risk management requires comprehensive harm reduction policies and procedures in place and emphasises adherence to policies and procedures. It further details that risk management will only be successful if it is a process involving all staff.

The policy document was supported by the responses in the clinical governance questionnaire that indicated that the risk management strategy included using stratified levels of physical, relational and procedural therapeutic security according to up-dated clinical risk. This was supported by the ability to provide high, medium, and



low security on one site. It was also stated that the ward staff would assess risk on an individual level on a consistent basis. This suggests a co-ordinated approach to the assessment of risk based upon the needs of the individual patient.

However, although the assessment of risk was clearly undertaken and documented there was evidence presented to the inquiry that suggested some concerns relating to the management of risk in the service. The main areas are documented below.

### **The Relationship between Risk Assessment and Risk Management**

There was general agreement from the staff who were interviewed that many patients were subject to levels of security that were not required given their assessment of risk. The Clinical Director of the service had carried out some work of the HCR-20 assessment of risk and its relationship to the appropriateness of the patient's placements on wards. The inquiry committee were informed that this data indicated that the management of patients was related to their risk assessment. In contrast, most of the staff interviewed, including members of the management team, reported that there were approximately three to five patients who required a high level of security and many patients were waiting for beds to become available before being moved to a less secure unit. The requirements of the service would seem to be related more to medium secure and low secure care with the exception of the above few cases. The Assistant Director of Nursing acknowledged that the rooms in Unit Three and Unit Seven did not need to be locked after 9pm. The reason for this was related to operational issues regarding low staffing levels, combined with the structure of the building with its many nooks and crannies, was primarily responsible for this continuation of the practice in this unit and not the clinical risk of the patients. They further commented that risk management was often based upon the needs of the most risky person within a clinical area rather than on individual need. The Director of Nursing admitted that risk assessment should be based on individual care and acknowledged that it was not being undertaken within the service. His view was that change could only occur incrementally in a service that had 150 years of a custodial culture but that it was an area that was a priority for change. Other staff also commented about the fact that most practice is based upon custodial care rather than in developing a therapeutic role.

### **Locking of Bedroom Doors**

There were many complaints from the carers and patients about the fact that all patients, with the exception of hostel residents, were locked in their room at 9pm each night.

In addition, it was reported that concerns about potential risks were the major factors in the locking of patients in their rooms from 9pm each night with the Clinical Director reporting that it was a nursing security concern with regards to lack of staff that would be needed to ensure the units were safe. At present, following the cessation of slopping out procedures, there are three members of staff on night duty in each of the high secure and maximum secure wards. Several other staff members stated that the concerns surrounding staff safety were the primary reasons behind this practice. However, this bore little relationship to the risk acknowledged within the assessments for the patients in the medium secure or low secure wards and for many in the admission wards. Hardly any staff members viewed patients in these areas as being a current risk to staff, other patients or themselves. It is acknowledged that there may be some need for some individual patients on the admission wards to be locked in their rooms but that presently this did not relate to individual clinical need. However, this would be more appropriately done on an individual risk assessment level rather than a blanket assessment.

One concern that was raised by ward staff related to the ability of staff to respond if a fire (or serious incident) took place at night that required the removal of patients from their rooms. Some ward staff stated that they were unaware of any fire drill involving patients and staff while other staff stated that they had never been involved in a fire drill and had only been to a fire lecture. The inquiry was also informed by the Senior Care Officers that one of the night staff would need to leave the main hospital building to open the main gate to enable emergency access to take place. We were unable to interview the health and safety officer and so are unable to detail whether any specific risk assessment or management plan has been devised for this eventuality.

### **Risk Management Plans**

Although a particular patient may have had a good risk assessment undertaken in his/her case notes, we found little evidence of specific risk management plans that were not mainly concerned with security (i.e. seclusion) or medication management responses. It was evident from examining numerous ward case notes that there were few nursing care plans addressing these problems. In addition, the nursing care plans that did focus on concerns about risk, also focused on security and medication responses. The current development of RAID training discussed in the section examining seclusion could help in developing more interpersonal plans for dealing with potential risk.

### **The Use of Leave**

There were numerous concerns expressed about the issue of leave particularly from patients and carers. Carers noted that they had to visit in the unit, and were not allowed to meet with patients in the grounds. They also told of having to walk on parallel paths to the patient when visiting Unit 7 even though there was no identified risk from the patient. Patients also stated that it often took a long time to be granted leave and there was little discussion with staff regarding their requests. The Head Social Worker stated that there were inconsistencies regarding leave and many carers and patients supported this view. The Senior Care Officers stated that lack of access to the grounds was due to security issues with often patients being unable to go into the grounds with staff escort, as this would leave the individual units with limited cover. There was a suggestion that in the future it might be preferable for units to work in tandem to allow for instance smokers from more than one unit to be allowed to go into the yard to smoke with staff from those units. This would allow for a doubling up of staff on to care for patient who did not wish to go outside. The Clinical Director also expressed concern over lack of security within the grounds and stated that it would be preferable to have a pin point system with beacons around the ground to assist in security.

### **Assessment of Risk of Suicide**

The assessment of the risk of suicide was reported in the clinical governance questionnaire to be undertaken by using standard clinical judgements and relying particularly on nursing observation. However, it was found that many ward records did not contain this assessment leaving it difficult to judge the amount and level of concern about potential suicidal ideation or behaviour. In addition, a number of patients indicated that if they verbalised any suicidal thoughts this would mean they were immediately transferred back to the admission ward and would then have to work their way through the system once more. This view was supported by a number of the ward staff that were interviewed. The consequence of this is that an effective assessment of the risk of suicide is compromised, as there is a powerful disincentive for patients to engage with staff to openly discuss their mental state and to acknowledge suicidal thoughts. The inquiry has subsequently been informed by the service that they are in discussion with Professor C. Webster (McMaster University, Canada) about the potential of using a new assessment tool designed to assess suicidal risk factors.

### **Untoward Incidents**

The untoward incidents policy document states that all untoward incidents covering near misses, actual incidents, and potential risk problems are recorded on the untoward incidents form. These reports are then collated by the Assistant Director of Nursing and discussed at the Risk Management Committee meetings as well as being circulated to the heads of disciplines, and team heads. In addition, it was reported that the senior management team would discuss the incident forms at their weekly meeting. The Risk management committee comprises of all three members of the Hospital Management Team and representatives from other grades and disciplines working in the service. It meets on a monthly basis with the main focus being to formally record and respond to all reported untoward incidents.

There is a system for assessing the level of importance of these incidents that was documented in the Untoward Incidents policy with incidents rated from category A to category D.

The categories were classified as follows:

**Category A** - involved any death whatever the cause,

**Category B** - included any life threatening activity, escape attempts from the Hospital, and serious sexual assaults,

**Category C** – included serious assaults, significant destruction of property, drug/alcohol abuse, sexual assault, and escape attempts from an escort.

**Category D** – included minor assaults, verbal abuse, and minor property damage.

We examined a number of completed incident forms, as well as the collated incidents reports for each month, and the Risk Management Committee minutes from July to October 2005. Unfortunately, we were unable to see the minutes of meetings after this date. The completed incident forms that were viewed typically only recorded a limited amount of information giving a brief description of the incident and the response.

The type of untoward incidents ranged from Category A to D though the vast majority were either Category C or Category D incidents. However, it was noticeable from copies of the untoward incidents form that there were few reports relating to control and restraint situations with this only being recorded on the form if there had been a specific physical assault (or an attempted assault) by a patient. This is surprising giving the level of seclusion that had occurred within the time period under discussion. The majority of comments relating to the incident only recorded the person whom the incident was reported. It was unclear from some reports as to how the incidents had been resolved especially those that had been resolved through the use of seclusion.

Many ward staff said that they were unaware of the Risk Management Committee responses and it was stated that often the person in charge of the ward would receive the report and file it away. We were also informed that no checks were undertaken to assess whether the information had reached ward staff though this was unable to be clearly established.

### **Levels of Observation**

Guidelines designed to assist staff in determining the appropriate level of patient observation were recorded on the Policy on Patient Observation. It notes that there are three levels of observation at the Central Mental Hospital. The clarification of these three levels is detailed in the policy document with reference to the potential for self

harm. The policy advises that when a patient is considered a serious risk of assault or absconding, a case review will consider the level of observation necessary.

***Level One - Ordinary Observation***

Where staff are aware of the whereabouts and current activity of the patients. Patients are allowed personal items in their room, have ordinary sheets and blankets, and can attend recreational and vocational activities. At night staff will routinely observe patients once every hour.

***Level Two – Increased Observation***

A patient's location and activities are monitored by a designated member of staff at fifteen minutes intervals. It is advised that staff members are only allotted to undertake this role for a maximum of two hours at a time. If the patient is considered at risk of self harm, the clinical team can consider using protective clothing and bedding. This must be recorded and regularly reviewed.

***Level Three – Continuous Observation***

This must be prescribed by a Consultant and reviewed on a daily basis. The rationale for this plan is that through constant one to one observation with continuous assessments of a patient's physical and mental state, there would be the opportunity to take immediate action to prevent self harm. It is prescribed that the staff member be within a reasonable distance of the patient at all times. Reasonable distance is defined as within earshot and sight of the patient and within a distance that allows immediate intervention. The written treatment plan should be drawn up and recorded in the medical and nursing notes. Further at night, patients on level three observations should have their doors unlocked with the assigned staff member having a clear view of the patients at all times. There was general agreement from staff that it was common practice for patients who were newly admitted to the Hospital to be placed on level 2 observations initially. This practice also extended to these newly admitted patients being in refractory clothing when they were locked in their rooms at night. It was also the case that a person placed in seclusion would automatically be placed onto level two observations.

**FINDINGS- RISK MANAGEMENT**

- 1. Risk Management Plans. The risk assessments carried out in the Central Mental Hospital were of a high standard and thoroughly assessed the risk factors related to individual patients.**

2. **The inquiry committee found little evidence of these assessments being used to form specific risk management plans. The management of risk within the TCP and nursing care plans focused on medication and security (primarily seclusion) responses.**
3. **Risk Assessment and Individual care. Following on from the comments in the previous section; there was limited evidence of individual care being based on the risk posed by the individual patient.**
4. **There was general agreement from staff that many patients were subject to levels of security that were far higher than their level of assessed risk. This led to many patients being in wards that reduced their capacity for rehabilitation and by implication would result in longer stays in the service. It is acknowledged that risk cannot be examined wholly on an individual basis. However, the view of the inquiry was that a balance between individual and ward context should be sought.**
5. **Locking of room at nights. All of the rooms in the Central Mental Hospital, apart for the patients in the hostel were locked by 9pm. There were few members of staff who supported the view that every patient in a ward (including Unit B) should be locked in their room at night. However, most staff were of the opinion that there was a need for some patients to have their rooms locked at night. The evidence collected showed that the locking of rooms was not based on any assessment of the individual risk posed by each patient but on general concerns about overall security.**
6. **Slopping Out. The practice of slopping out ended during the period of the inquiry and this is to be commended.**
7. **Time taken to open bedroom doors at night. There were numerous complaints from patients and carers about the time it took for staff to open rooms to allow patients to go to the toilet. These views were supported by comments from many staff members.**
8. **Parole. The evidence gathered showed that there were inconsistencies in the granting of leave (such as patients having unaccompanied leave outside the grounds but no parole inside the Hospital). There were**

also concerns raised by patients and carers, and acknowledged by a number of ward staff, that the granting of parole often took a long time. The policy again did not appear to be based on the individual risk posed by the patient.

9. **Escorted visits in the grounds.** Most patients had to be escorted to any location outside of their ward. On some wards such as Unit 2 and Unit 3 this would require all patients to go to the exercise yard at given times to allow those patients that smoked to have a cigarette. Due to security concerns, and the lack of ability to assess patient on an individual level, those patients who were non-smokers were required to go to the exercise yard irrespective of whether they wished to go or not.
10. **Escorts for Therapeutic Activities.** The ability of patients to go to therapeutic activities or outside visits was adversely effected by difficulties in providing escorts.
11. **Privacy.** Due to security concerns there was constant monitoring of patients private communications. Staff were required to open letters coming into or going from the Central Mental Hospital and also to sit near to patients when they were on the phone to be able to listen in on any telephone conversations. The former had been ruled as illegal following the Central Mental Hospital asking for a legal ruling on the practice. However, this had been opposed by one of the staff unions who had continued to undertake the practice. Once again, neither practice was based on an individual assessment of risk but on a blanket risk strategy applied to the whole ward or hospital.

## **RECOMMENDATIONS-RISK MANAGEMENT**

1. **Individual Risk Assessments -** There is a need for the individual risk assessments to be used to develop clear individual risk management strategies for each patient.
2. **Individual risk management plans.** There is an acknowledgement that risk management strategies have to take into account the overall risk posed within an environment. However, any risk management strategy



that is influenced by the communal environment should be clearly detailed in a finalised individual risk strategy.

3. **Locking of Rooms.** The locking of rooms should be determined primarily on an individual basis and should be determined by the risk posed by the individual patient. It is acknowledged that at times the communal safety of the unit will need to be taken into consideration which may require some rooms to be locked. If this is the case, this should be clearly documented in the case notes.
4. We suggest that the rooms on units are unlocked on a progressive basis with this commencing on Unit 7. The outcomes of this development can then be evaluated prior to it being introduced on Unit 3 with any adjustments following the evaluation. We recommend that this graded approach be used to allow all units as having unlocked bedrooms while again acknowledging that the communal safety of the unit will need to be taken into consideration and that some rooms may be locked. If this is the case, this should be clearly documented in the case notes.
5. The locking of the bedrooms of women in Unit A should be examined on an individual basis.
6. Those patients whose bedrooms are locked at night should have this formally reviewed at regular intervals of not more than every three months.
7. Those patients who have their bedrooms locked should have call buttons in their rooms to be able to communicate with staff that they require assistance. There should also be an agreement in place that all patients will get a response from staff within two minutes of requesting assistance (unless there are exceptional circumstances).
8. **Escorts.** Leave within and outside of the hospital grounds should be determined by the individual risk posed by the patient and based on their risk assessment.
9. **Ground leave.** Unescorted leave within the grounds should be allowed and based on the assessment of individual risk.
10. **Application for Unescorted ground visits.** There should be a clearly detailed procedure by which patients and staff are aware of how patients can apply for parole. The results of this application and reasons (if the

**application is unsuccessful) should be relayed to the patient and recorded in the patient's case notes.**

- 11. Opening Mail. Unless there is a clearly identified risk (which is noted in the patient's case notes) staff should not either open outgoing or incoming mail. If the risk assessment identifies that a patient requires their mail to be opened, this should be done by two members of staff in the presence of the patient.**
- 12. Telephone Privacy. Unless there is a clearly identified risk (which is noted in the patient's case notes) staff should not listen in on telephone conversations.**

## SECTION 8 – PROFESSIONAL GROUPS

### MEDICAL

#### Overview

There are five consultant-led multidisciplinary teams and each consultant is supported by a senior (either Specialist Registrar or Clinical Research Fellow) and junior trainee. Five placements for basic specialist training are associated with the four schemes for the Dublin area and one with the West of Ireland and Galway scheme.

Placements for higher specialist training comprise two specialist registrars on the general adult scheme, one lecturer based at Trinity College and three or four Clinical Research Fellows who combine research and audit work with clinical experience in forensic psychiatry supporting a year's accreditation for higher training. The forensic service does not experience difficulties in recruiting medical staff and attracts doctors of high calibre across all levels of seniority.

#### Roles and Responsibilities

Consultant staff have a busy and varied work schedule with a range of responsibilities including inpatient work, referrals and assessment, prison sessions and follow up of a small number of community patients. Consultants each offer a consultation service to particular areas of the country for forensic advice and the medical staff support the court service in providing court reports for serious offenders when appropriate.

Medical staff are actively engaged in patients' care from pre-admission assessment, initial assessment, continuing care and discharge planning. Dr. Kennedy carries the most significant management role in being Clinical Director in addition to his clinical responsibilities. His overall responsibilities are onerous. Dr. Mohan has specific responsibilities as Clinical Tutor in organising the educational placements, supporting trainees and liaising with parent schemes. Dr. O'Connell has an academic post as Senior Lecturer and Dr. Kennedy has a clinical senior lectureship with Trinity College. All the consultants undertake regular teaching commitments including provision of a course in risk assessment provided on two occasions each year. Medical student placements are accepted from Trinity College, University College

Dublin and the Royal College of Surgeons. The consultant group support a wide range of academic and policy initiatives both with the Irish College of Psychiatrists and Criminal Justice agencies. For example the service has provided extensive training in new mental health legislation and two consultants assist the Leave Board.

The junior N.C.H.D.s are involved predominantly in inpatient work including preparatory work for case conferences with some responsibilities in prison liaison and the specialist registrars and lecturer have wider responsibilities with prison mental health care, preparation of reports and community work. They are also involved in some group work on illness awareness and drug and alcohol misuse. Medical notes reviewed by the Inquiry Committee were uniformly of high quality with regard to assessment, medical aspects of the T.C.P. and progress notes.

### **Multidisciplinary Team Function and Care Planning**

All consultants have patients across all areas of the hospital except on Unit 4 where all the patients are under Dr. O'Connell's care. Consultants were satisfied with the level of support in each M.D.T. from Occupational Therapy, Psychology and Social Work but concerned that nursing and care staff should play a greater role. Central rostering was felt to be a major obstacle to progress in this area. The N.C.H.D.s are closely involved in preparation of the T.C.P. and associated risk assessment. The group was satisfied with the level of multidisciplinary input. Formal responsibility for completion of the document varies between teams and the community mental health nurse completes this on one team.

### **Training and Continuing Professional Development**

Both consultants and N.C.H.D.s considered that they received good support for continuing professional development. All the N.C.H.D.s had regular, timetabled individual supervision with their consultants and were very satisfied with the quality of supervision. Consultants are able to attend external conferences of relevance to their work and take an active role in supporting and presenting research and audit.

The Inquiry Committee had some concern that the N.C.H.D.s had a limited understanding of issues of concern which in contrast were shared both by senior members of staff, consultants at the hospital and the Inquiry Committee. For example

the group of N.C.H.D.s did not appear to have a good understanding of alternatives to seclusion. The group accepted that all clothing should be removed when patients were secluded on account of hospital policy. The level of freedom patients enjoyed was considered to be dependant on individual risk assessment. The group had not visited other forensic psychiatry services.

### **Specific Issues**

- 1) The consultants were concerned about providing acceptable and consistent care to women patients and felt the differing needs of individual patients and the number of doctors working to the unit to require further consideration.
- 2) The consultant group thought the consistent model of nursing care, availability of space and ready access to the garden to have been significant factors in the improvement and reduced use of seclusion on Unit 4. They had concerns about the level of seclusion on other units and found being unable to relate to consistent ward management difficult in reviewing clinical management strategies.
- 3) Ongoing concern about exercise, healthy diet and weight management.
- 4) The consultant group reported that discharge planning was problematic due to the lack of step-down community facilities and reluctance of community and rehabilitation services to become involved.

### **FINDINGS- MEDICAL**

- 1. The CMH benefits from a skilled and motivated consultant group who provide a range of clinical, teaching, research and governance responsibilities.**
- 2. Medical staff play a prominent role in assessment and treatment. Documentation is of a high quality and clinical supervision and professional development given a high priority.**
- 3. The Inquiry Committee was concerned that the manner in which consultants work on all units within the hospital meant that the**

**leadership potential of the medical staff working closely with particular units was insufficiently utilised to promote best practice.**

- 4. The NCHD's had a limited understanding of alternatives to seclusion and the role of risk management in everyday working practice.**

#### **RECOMMENDATIONS-MEDICAL**

- 1. Consideration should be given as to how best the medical staff can be aligned with particular units in order to utilise their knowledge and skills in developing a multidisciplinary model of care.**
- 2. Training initiatives for NCHD's should include consideration of alternative strategies to seclusion and visits to other forensic psychiatry services.**

## **OCCUPATIONAL THERAPY**

### **Overview**

The Occupational Therapy Manager was appointed substantially in 2005 following a two year period of acting up of the present post holder. There has been sustained support from the Clinical Director for the Occupational Therapy Manager to develop the discipline such that there are now additionally two senior Occupational Therapy posts, three Basic Grade and one Assistant. At the time of the Inquiry Committee's visit one senior post was vacant causing some pressure on other staff and the third Basic Grade post was recruited to during May 2006. The C.M.H. now has a skilled and energetic group of Occupational Therapists across all multidisciplinary teams. They have implemented unit based occupational therapy groups on Unit A, the rehabilitation Units 3 and 7 and Unit 4 (S.A.B.U). Their ability however to fulfil their role and develop further therapeutic opportunities for patients appears to be seriously impeded both by lack of physical resources and by cultural and organisational issues.

### **Roles and Responsibilities**

Occupational Therapists work with patients and other staff to assess the functional abilities of the patient taking account of their past roles and the environments they have experienced. They then generate goals in collaboration with the patient aimed at addressing identified deficits which work towards specific goals to improve overall quality of life. Occupational Therapists at the C.M.H. are involved in initial and ongoing assessment, individual and group therapy. They work both at the C.M.H. site and at Usher's Island and can also provide some community work with those patients who resettle in Dublin. Occupational Therapists at the C.M.H. are able to provide one to one work in relation to individual needs such as anxiety management, community awareness, budgeting and work with Social Work colleagues in the "Wellness" psycho-education group programme. They also provide graded activities in arts and craft and some drama and arts based work. However there was widespread concern from the Occupational Therapists group that they found it difficult to utilise their main tools of intervention based on occupation and activity. The lack of an A.D.L. kitchen at the C.M.H. site was of major concern at the time of the inquiry visit. There is a kitchen available at Usher's Island which can be used by two patients per session but

the Inquiry Committee were informed that many patients were discharged without full assessment of activities of daily living or only resumed these activities after many years of admission. Community programmes can be facilitated for patients on Unit 7, the hostel and Unit A but the group reported resistance to such activities both from inside the hospital and from outside agencies. Patients routinely came to Usher's Island by hospital transport and it has proved arduous for Occupational Therapy staff to negotiate escorted use of public transport for an individual patient in order to promote his skills in this area.

### **MULTIDISCIPLINARY TEAM FUNCTION AND CARE PLANNING**

Occupational Therapy staff provide strong support in their area to each consultant led M.D.T. but the Inquiry became aware of difficulties in the interface with the Vocational Training Department and in joint working with nursing and care staff on some of the wards.

There is a weekly meeting between Occupational Therapy and Vocational Training where patient programmes are co-ordinated but the meeting does not appear to have a role in creatively working to provide a greater range of activities or to tackle issues of shared concern. User groups independently commented about this area of concern without prompting. It was reported that a fear of encroachment on vocational officer roles seems to impede the development of a greater range of activities and a more cohesive approach.

### **Ward Culture and Therapeutic Activities**

Difficulties in furthering therapeutic activities on the wards were reported as only partly due to the lack of physical resources. Facilitation of both individual and group work varied considerably between different wards and also between different members of ward based staff. The women's service was considered to be more consistent and facilitating in its approach.

At the other extreme the Inquiry Committee were informed by many sources that it was not unusual for ward based staff to sit in on groups and to either read a newspaper or text on a mobile during sessions. Criticism of Occupational Therapy staff in the



presence of patients also occurs. The Occupational Therapy group were concerned that if they complained about attitudes that were deleterious to true multidisciplinary working that their work would suffer further through further limitations being put on their access to patients.

### **Training and Continuing Professional Development**

The Occupational Therapy Manager lectures in Occupational Therapy at both Trinity College, Dublin and University College Dublin. Some Occupational Therapy students are accommodated for placements at the C.M.H..

Ongoing supervision was reported as irregular within the group and deserving of some attention as to prioritisation and planning. Similarly although the designated Head has now secured a budget for professional development access to Occupational Therapy forums outside the C.M.H. was perceived as difficult. This may be a reflection of the fact that the discipline did not have a full complement of staff until recently. Although the Occupational Therapists recognised there was some value in being based within a multidisciplinary team office this may be associated with a greater need for a more frequent formal supervision and peer group support.

### **Specific Issues**

#### **Designated Areas for Occupational Therapy**

Occupational Therapists do not have a designated area where they can carry out assessments and conduct therapeutic activities. Room availability on the wards is problematic and interruptions and distractions were reported to be common during therapeutic sessions. Limited protected time for therapeutic work within the daily schedule and patients missing sessions because of unavailability of escort staff were also of concern. The lack of kitchen facilities suitable for assessment of daily living skills is a specific problem but the need for a quiet area where patients can gain enjoyment from focussed occupation is also important. The Occupational Therapists were not able to offer supervised use of kitchens on the units including the rehabilitation wards at the time of the Inquiry's visit. We were informed on the 30<sup>th</sup> of August 2006 that use of the kitchen on Unit 3 for A.D.L work had been secured. Patients can use the laundry facilities.

### **Budget and Supplies**

Occupational Therapy staff have protracted difficulties in ordering supplies of specialist material which has to be done through stores. The budget has not been specified. It is hoped that the appointment of a hospital administrator will address this issue.

### **FINDINGS-OCCUPATIONAL THERAPY**

- 1. The Inquiry found that the Occupational Therapy Department provided a good service as part of the multidisciplinary team. Their input was limited by the lack of resources such as therapy rooms and training kitchens.**
- 2. The interface between Occupational Therapy and Vocational Training is problematic and this was considered to have a considerable impact on care planning.**
- 3. There is variability in how far ward based staff work jointly with Occupational Therapy and facilitate the therapeutic programme. The interface on the women's service was reported to work well but in certain areas staff do not readily facilitate the work and have been known to disrupt therapeutic sessions by reading the newspaper or texting on mobile telephones.**
- 4. Ongoing supervision for staff was available but deserving of some attention as to prioritisation.**

## **RECOMMENDATIONS-OCCUPATIONAL THERAPY**

- 1. Adequate resources must be developed to enable the Occupational Therapy Department to carry out appropriate therapy. This should include therapy rooms, training space and equipment.**
  
- 2. The Head of Occupational Therapy should be supported by other staff and middle management in developing a therapeutic programme that best meets the needs of patients. A common referral path and review process should form part of a coherent approach involving Occupational Therapy and Vocational Training.**
  
- 3. Occupational Therapy must be facilitated in ward and vocational areas and recognised by all staff as an essential part of individual care plans.**
  
- 4. A programme of supervision must be in place to ensure all grades of OTs receive appropriate levels of supervision and support. This should include attendance at Occupational Therapy forums outwith the C.M.H. and visits to other secure facilities.**

## **SOCIAL WORK**

### **Overview**

The current head of social work was appointed in 2003 and there has been consistent progress over the last three years in development of the role. There are currently six W.T.E. posts in the social work team and a community rehabilitation support worker. The development of systems of collaborative working with local social services has been a priority and a service level agreement has been set up with Dublin mental health hostels. Work with carers has been a further priority as has setting up arrangements for liaison with regard to children and child visiting and the provision of a child friendly visiting facility. All these areas have required sustained work and much progress has been made. The carers' group was initially set up as a support network and its roles and responsibilities have now evolved to encompass both monitoring and involvement in strategic change. Partnership working is in place both with the Department of Social Welfare, Children and Family services and with the following voluntary organisations:

*A range of housing agencies*

*Alcoholics Anonymous*

*The Irish Advocacy Network (provides information sessions for patients)*

*Mental Health Ireland*

*Schizophrenia Ireland*

*Spirasi and Pavee Point (minority interest groups)*

*Narcotics Anonymous*

*GROW*

A user led support group is currently being developed with Narcotics Anonymous.

### **Roles and Responsibilities**

Social workers at the CMH are involved with assessment and ongoing work with both individual patients and their families. In addition to assessment of family and social aspects of presentation and delineation of social care needs social workers play an important role in the MDT and in therapeutic groups such as the “wellness” group, drug and alcohol groups and current affairs. They actively participate in programme planning meetings which focus on development of a therapeutic working day. Social workers actively liaise with families although formal family work has not yet been developed.

### **Multidisciplinary Team Function and Care Planning**

The social work department felt that the MDTs functioned well although the absence of key working and the two day shift pattern for unit based staff made this particular team interface more problematic. The group were of the view that the patients’ role in the multidisciplinary team meetings needed to be developed. The issue of having a single multidisciplinary team for each ward has been discussed at management level. It was felt by the social work department there are advantages and disadvantages to the current approach, with continuity of care for patients being the most important consideration.

The social work group saw the TCP as the appropriate focus of case conferences and confirmed that each care plan identified a care co-ordinator but noted that nursing staff do not take on this role. It is policy for all patients to be given a copy of their care plan. The group acknowledged difficulties in furthering a consistent approach to risk management and constraints on developments in patient care. The initiative of a Sli na Slainte health walk in the grounds was reported to be an example of where maintenance and I.R. issues are impeding progress.

A major source of frustration for social workers in aftercare planning is the lack of co-ordination between services with no sense of patients having care pathways through the Irish Mental Health System despite concerted work by the C.M.H. social workers. The Inquiry Committee’s attention was drawn to disparity in benefits for patients detained as guilty but insane and the impact on rehabilitation of delays and inconsistencies in leave agreements from the Department of Justice e.g. a patient may

have permission to attend a course each day but would need to seek further agreement to take the patient to an interview (albeit accompanied).

### **Training and Continuing Professional Development**

The social work department has strong training links with third level departments and are involved in local training including the weekly MDT teaching programme and formal training in risk assessment and risk management. Four CPD days per annum are co-ordinated through the National Group for Social Workers in Adult Mental Health and other educational needs are identified and supported through individual supervision. The social work department provides student placements for students from Trinity College, UCD, UCC and UCG.

### **Specific Issues**

The social work group raised a number of additional issues of concern to them professionally although they considered that despite some difficulties they have been able to progress many initiatives as a professional group and provide a good service to patients. The physical environment and poor maintenance was of concern. The group were exercised by the lack of rehabilitation facilities for women, the impact of this on longer term patients and the culture of the women's service with regard to male staff being involved in control and restraint. The group had concerns relating to the use of seclusion and the need for this to be reviewed by all disciplines within the MDT. They expressed considerable relief regarding the opening of Unit B and Unit 4 in this regard.

### **FINDINGS-SOCIAL WORK**

- 1. The development of systems of collaborative working with local services has been a priority and a Service Level Agreement has been set up with Dublin Mental Health Hostels.**
- 2. The establishment of carers support and forums is to be commended.**
- 3. Liaison for children visiting and the provision of child friendly visiting facility has been established.**
- 4. There are positive examples of partnership working with a range of voluntary and statutory agencies**

5. **There is lack of involvement of nursing staff in MDT functioning and TCP process.**
6. **There are difficulties with aftercare planning and lack of co-ordination between services**
7. **There are disparity in benefits for different patients**
8. **There is positive emphasis on providing training**
9. **There is concern regarding the poor physical environment**
10. **There is lack of rehabilitation facilities for women**
11. **There are reports of involvement of male staff in restraint of women**
12. **There are concerns expressed about the general use of seclusion**

#### **RECOMMENDATIONS-SOCIAL WORK**

1. **Nursing staff must be more involved with the MDT process and the TCP. Self staffing on units would enhance the process.**
2. **A working Group should be established with the HSE to examine future placement in the community and other health care provisions for patients**
3. **Essential maintenance should be carried out on all units and a maintenance programme put in place.**
4. **The provision of services should be reviewed in line with recommendations in Section 4 and 5.**
5. **The use of seclusion in the CMH should be revisited and alternatives to seclusion explored.**

## **PSYCHOLOGY SERVICE**

The Psychology service is a new service within the C.M.H. Recruitment of psychologists has been continuing over the past 12 months. At the time of our visit there was one senior grade psychologist and two basic grade psychologists. There are currently two further vacancies for psychology. There are also two psychology project workers. It is planned that there will be a psychologist on each multidisciplinary team, bringing a total of seven psychology W.T.E.s. The senior clinical psychologist meets with the Clinical Director on a weekly basis and reports professionally to the lead clinical psychologist for the area.

## **ROLES AND RESPONSIBILITIES**

The Psychology service provides active input into the multidisciplinary team, partakes in weekly multidisciplinary team meetings and case conferences, and also provide written reports where necessary. Psychologists provide neuropsychological assessment, psychodynamic assessment and intervention, sexual and non sexual risk assessment, functional behavioural assessment and interventions relevant to personality disorder and psychopathy and are developing an Enhanced Thinking Skills (E.T.S.) group intervention. The psychology service provides training and teaching input into training courses in clinical psychology, forensic mental health. There are two placements for a trainee clinical psychologist within the service. Within the Selective Behaviour Unit the clinical psychologists provide assessment and management of challenging behaviour. The psychology service has been involved in introducing and training in RAID® and 32 staff are trained in RAID®. Unit 4 and Unit B have piloted RAID® training. Staff have felt empowered by this training and RAID® has helped staff feel part of M.D.T. There has been positive feedback from staff regarding RAID® training. Psychologists are going onto each ward to develop RAID® for each service user. RAID® training has ceased at the moment due to difficulties in releasing staff to attend. It has also been difficult to obtain rooms to hold RAID® training and staff to attend the course.

The basic grade psychologists meet weekly with the senior grade psychologist for supervision. Funding is available for external supervision and opportunities for professional development are excellent.



The psychology group raised a number of issues with the Inquiry Committee:

**1. Group Work and Interventions**

There are a number of groups operating in the C.M.H at present. These include GROW, Wellness Group, symptom control group as well as a current affairs group. Group work in substance misuse is led by the clinical nurse specialist in addictions. There is no therapeutic family work at present. Psychology is not aware of any unit staff co-presenting groups on the wards, although they feel that unit staff should be involved. Some staff are showing an interest in group work.

**2. Key Worker**

The lack of a key worker system was considered by the Psychologists to impede sustained psychological work and clinical psychologists were strongly in favour of the implementation of such a system. Although the general reason given for the lack of key-working, it was felt that there is still some resistance to the introduction of a key worker system and that there needs to be a change in culture and attitude towards implementation of such a system.

**3. Seclusion**

The Head of Psychology feels that seclusion is used responsibly in the C.M.H. and that it is not used as a punishment. Its use varies on units. However on Unit A (female unit) it was felt that seclusion is very often overused due to the fact that the unit is poorly designed resulting in difficulties in separating distressed service users from other service users. It is hoped that the introduction of RAID may help reduce the level of seclusion. A programme was developed for one service user on Unit A to move out of seclusion. This was met with resistance by staff, who threatened to walk out of the unit if the service user came out of seclusion. It was felt that there was a lack of skills to deal with women service users particularly those with severe borderline personality disorder. At weekly M.D.T. reviews service users who were in seclusion are discussed, psychology would be allowed to give their views. Feels a more separate Committee should be in place to discuss the issue of seclusion for individual service users independent of clinical teams. There is a Committee looking at the current approach to seclusion, restraint, best practice, training and

development meet every month. It is felt that there should be more frequent discussion on seclusion and more independent assessment.

#### **4. Multidisciplinary Team Functioning**

It is felt by the Psychologists that care officers/nursing staff are not involved enough in the multidisciplinary team meetings. There has been some resistance from these staff in becoming involved. The core M.D.T. are always present at team meetings. However the attendance of ward staff is variable. It is generally the same nurse who attends the M.D.T. meeting. Some teams meet in the board room, due to lack of rooms on wards. However there is a move away from meeting in the board room to meeting on the ward which is felt to be more appropriate. Ward rounds are carried out in the C.M.H. There is quite a traditional approach regarding ward rounds. Each service user is brought into the nursing office and the multidisciplinary team sit around and talk to the service user. If the interview rooms are free they are used instead of the nursing office. It is more comfortable to meet in the board room. Only three M.D.T.s have psychologists on the team. It was felt that there is little input from the multidisciplinary team members on the wards and that if more disciplines have more presence on the units it would enhance change.

#### **5. T.C.P Care Plans**

There are two care plans in operation, a nursing care plan and the Care and Treatment Plan (T.C.P). The Psychology service indicated that the nursing staff are not involved in the T.C.P. and the T.C.P.s were felt to be rushed, not used to its fullest and not of great relevance to the service users. The nursing care plans show little addressing of and management of behaviours. The T.C.P. contains case conference summary, diagnosis and risk assessment. It is rarely referred to for service user management.

#### **6. Room Space**

The psychology service finds it difficult to access office space. They require a room four times a week for Anger Management and E.T.S. which has been promised. The now closed Unit 1 would be suitable but as it is now closed it is unavailable. There is no space to interview service users on units. All disciplines have problems with acquiring room space. The psychologists state that there have been problems with

ward staff interrupting sessions and they have to insist that ward staff cannot interrupt sessions and should attempt to minimise noise disruption.

#### **FINDINGS-PSYCHOLOGY SERVICE**

- 1. The recruitment of psychologists to all MDT's is positive.**
- 2. The psychology service is to be commended for introducing the RAID® training.**
- 3. The Psychologists concur that nurse and care officers are not involved sufficiently in the T.C.P. and case conferences and that the lack of a key worker is impeding proper care planning.**
- 4. There are insufficient therapy and interview rooms for psychology.**
- 5. In common with Occupational Therapists, Psychology sessions are interrupted by ward staff.**

#### **RECOMMENDATIONS-PSYCHOLOGY SERVICE**

- 1. Adequate resources should be made available to the psychology department to enable it to carry out its functions**
- 2. Psychology must be facilitated in wards and recognised by all staff as an essential part of the individual care plans.**
- 3. Unit staff should be supported in being involved in co-presenting groups and facilitating staff programmes.**

## **NURSING AND CARE OFFICERS**

### **Overview**

Nurses and Care Officers form the majority of the staff employed at the C.M.H. There are approximately 111 ward based staff employed within the C.M.H. There is a national policy of not employing Health Care Assistants (HCA's) to help with client care. Therefore, all nursing staff are qualified mental health nurses. Traditionally the hospital was staffed by care officers. Now care officers are replaced by nursing staff and no new care officers have been employed since 1983. There are currently 47 care officers still in post. Mental health nurses have been employed at the Hospital since 1992 with no new care officers employed from this time. The care officer contracts were similar to nurses but had not been reviewed since the introduction of nurses into the C.M.H. There is some potential for care officers in developing rehabilitation and activity based roles.

The nursing role has evolved within the hospital since 1992. In 1999 the hospital adopted the role of the Clinical Nurse Manager 2 (CNM2). The CNM2 works opposite to a Senior Care Officer who each have responsibility for a shift of duty with staff working a two day on two day off shift system. In the absence of a CNM2 qualified nursing staff are under the management of senior care officers, who in the majority of cases have no nursing background. Currently there are no CNM3 or CNM1 posts. The principal care officers stated that the current shift system did not promote continuity of care. They also expressed concern that some disciplines did not work weekends. They stated they tried to ensure some core staff on each unit but this was not always possible.

The Director of Nursing (D.O.N.) has developed a proposal to reform the nursing/care officer management structure currently going through the Labour Court. The proposal is to introduce ward managers to each unit. The ward manager would have a defined management role within a specific unit. It is envisaged they will provide strategic and clinical leadership and direction for their unit. The ward managers will report to Assistant Directors of Nursing (A.D.O.N) and ultimately to the D.O.N. The proposal also outlines the development of sixteen Team Leader posts at a Clinical Nurse Manager 1 (CNM1) level. The team leader will have day to day operational

responsibility for the unit and will act under the guidance of the ward manager. The proposal earmarks the provision of nine ward managers, one for each unit, including the hostel and two night positions.

Maintaining an appropriate number of staff within the hospital is a problem. The employment ceiling placed on public services by the government has had a significant impact on the service. At the time the ceiling was introduced some 30 nursing posts were lost due to the vacancy factor at the time. It was stated that the service needs to employ 111 staff to effectively staff all units. Currently the average staffing shortfall is twelve per day which is covered by overtime. The hospital has a history of industrial relations issues. It has been reported by both management and trade unions that relations have improved. However there remains a concern from management that if the goodwill of the staff to cover overtime was withdrawn then the service would not function. It has also been widely reported by management that they have fears that strike action may be invoked if relations deteriorate. It was strongly emphasised by management that the service needs a more robust line management structure within the clinical areas and it is hoped that the proposed introduction of ward managers will provide this structure.

It was reported by senior nursing staff that they have no autonomy or responsibility for budgets, recruitment of staff or disciplinary procedures. All of these responsibilities are held centrally within the Health Service Executive (HSE). When the inquiry team met with representatives from the Human Resources Department the issue regarding disciplinary procedures was challenged. It was stated that members of the senior management team had had training in a programme called Effective People Management and that line managers were empowered to deal with disciplinary procedures and there were comprehensive policies to guide staff and the support of the HR Department to implement the policies. The ADON's stated that they were aware that there was HR support but were unsure of any training available. They have all completed a management course. They stated they had regular meetings with the D.O.N but no individual supervision.

The role of the ADON/SCO includes the supervision of those in charge of the unit to ensure a high standard of care is being provided to patients on a daily basis. The

ADON's reported that they have divided the service between the three post holders. One has responsibility for the admission units sharing responsibilities with the senior care officer in charge of security, one has responsibility for Units 2, 3 and 4 and the other for Unit 7, the hostel and Ushers Island. They felt their role focussed on developing policies and disseminating these to staff, recruitment of nursing staff, audit, monitoring nursing standards, staff support and the deployment of staff. In addition to the ward staff there are six Community Psychiatric Nurse's (CPNs) and a Clinical Nurse Specialist (CNS) for dual diagnosis employed by the service. The Director of Nursing has overall responsibility for all nursing and care officer staff and is a member of the Senior Management Team of the service. In addition, the service regularly has nursing students on placement from nurse training schools from around the country. Students are normally in their 2<sup>nd</sup> to 4<sup>th</sup> year of training and have a placement of between two to six weeks. The training department of the C.M.H. oversees the placements. A number of specific issues were raised during the course of the inquiry and these are now detailed.

### **Key working**

Many staff commented upon the fact that there was no clear key working system in operation on the wards. It was also suggested that different models of care were used on different wards. The inquiry was informed by a number of staff that a keyworking system had been introduced on one ward by one shift but not by the other shift. There were a number of comments from ward staff members and members of the Multi-disciplinary Team (MDT) that there was a resistance to the introduction of a Keyworker system from some ward staff members. The consistency and quality of the care being offered to patients from the ward staff was therefore seriously compromised. The ADON's agreed there were inconsistencies in the care offered by staff on the ward. Additionally, the Director of Nursing acknowledged that although the MDT approach to planned care had developed over the last few years, this had been difficult to introduce in relation to nursing due to the lack of a clearly identified primary nursing system. There were plans for staff to be allocated to a specific team though the inquiry committee was unable to ascertain any clear strategy for its implementation. The prevailing view had been that an incremental change in ward culture would allow a gradual introduction of new practices and ways of working. However, it was conceded that this was not working with frustration at the lack of

progress and that this needed to be addressed as a matter of priority. There was a view put forward that the proposal of one manager per ward would empower staff as that would allow for a greater consistency of approach. It was further suggested that to assign staff into three groups working in specific areas (admissions, through care, and rehabilitation) would also help in developing consistent care approach.

The Director of Nursing reported that Multidisciplinary Teams are now formed but lack of nursing input due to the lack of a keyworker system or primary nursing. The principal care officers stated that if a keyworker system were to be introduced that their staff would require training as this is an unfamiliar role for them. They also stated that a number of nursing staff did not want change to the current systems and the introduction of a keyworking system. The ADON's reported that a keyworker system was needed to increase the nursing input to the MDT.

### **Nursing Care Planning**

It is the responsibility of the Unit Manager to coordinate and supervise the delivery of care and treatment planned for the patient during their stay in the hospital. Once notified of a pending admission the person in charge of the unit shall assign a staff member to carry out the admission procedures and ensure continuity of care through assignment of a key worker/primary nurse and associate keyworker/nurse. The Through Care Policy within the CMH states as it's aim to be an overarching structure for four component policies, admission policy, MDT roles and practice (as a service level agreement), discharge policy and aftercare policy. Among the objectives of this policy is to meet the needs of the patient including carrying out an assessment of those needs, from many aspects including mental, physical and psychological health. In the forensic psychiatric service it also requires detailed assessment of risk/relapse indicators, for the patient and others and a strategy to manage the identified risk.

It is stated that the care plan will only be effective if there is agreement from the people involved that they are able to participate as planned and there is involvement of the patient and the carer in the decision making process. The Through Care Policy applies to all patients within the CMH. A care plan shall be formulated and communicated to the referring agent, regardless of the length of stay in hospital. The

emphasis is on continuity of care from first referral through to discharge and aftercare. They reported that nursing staff are not involved in the Through Care Policy.

However, the role of the nurse is clearly stated in the policy. Among the specific responsibilities are to ensure that a care plan is formulated, involving the patient in the process at the earliest opportunity, while taking their mental state and risk assessment into consideration. They also:

- Monitor, supervise and coordinate the delivery of the care and treatment in accordance with the care plan.
- Ensure review dates are set and outcome measures for each intervention are agreed, evaluated and revised as necessary.
- Identify, through observation and communication with the patient, their needs and concerns and liaise with the other members of the team to aid their assessment of the patients needs.
- Record and report observations and progress, through attendance at team meetings and case conferences.

Within the nursing care plan, specific nursing problems should be identified and regularly reviewed and adjusted depending on the findings of this review. In some settings it was stated that the nursing care plan was reviewed each week though the majority of ward staff interviewed stated this was not the case. When examining the nursing records of a selection of patients, the inquiry found that the vast majority of the nursing care plans were not up to date. Although there were daily records and weekly progress reports for most of the patients, these were mostly non-specific and not related to the care plan. The most compelling evidence over the quality of the care plans came from the audit of care plans undertaken by one of the ADON's. The audits only examined a) whether the care plan had been completed and b) whether it had been reviewed. The nature and quality of the care plan and review were not assessed. Even with this limited criteria, many did not have any current care plans in the initial audit although this was addressed. In addition, the majority continued to have care plans which were not reviewed with only three out of seventy four reviewed being current and up to date.



The clinical governance questionnaire stated that the involvement of service users should be part of the risk assessment and TCP procedures. Although not explicitly stated, it is evident that this should include nursing care plans. During the interviews with patients, few could recall having any input into their nursing care plans nor in having any involvement in reviewing these care plans. Many ward staff also stated that there were no quality improvement programmes and no clear monitoring of care.

It was interesting to note that the introduction of a one team approach in SABU had resulted in a more consistent care package being offered to service users and greater involvement of nursing staff in the development of nursing care plans.

### **Relationship to Multi-Disciplinary Team**

The hospital has a Through Care Policy which states that the admitting Consultant psychiatrist remains with the service user through out their admission. This means that the MDT linked to the consultant follows the service user throughout. Nursing staff are not allocated to MDT's. However Unit 4 has recently been developed as a challenging behaviour unit under the responsibility of one MDT. During meetings with the inquiry team the D.O.N and principal care officers stated it was their preference to have dedicated teams on each unit, as Unit 4. This would enable nursing staff and care officers from each unit to be allocated to an MDT and assist each unit in becoming self staffing. However, subsequently, we were informed in writing that the Director of Nursing did not have a preference for dedicated teams on each unit as Unit 4. This would enable nursing staff and care officers from each unit to be allocated to an MDT and assist each unit in becoming self staffing. It was reported that the through care system is based on the Care Programme Approach in the UK. Section two of the policy refers to the role of the MDT in the admission of patients. The aim of this part of the policy is to set out an operational description of the services provided to patients by the multidisciplinary teams and the optimum role of each member of the team, so that complementary and cooperative services are provided to the patient.

There was a fairly consistent agreement from ward staff and members of the MDT that ward staff (and especially nurses) were not viewed as individual members of the MDT and so worked in isolation in developing their care to patients. This was clearly

demonstrated by the fact that the nursing files were separate from MDT notes. The result of this lack of involvement was that many ward staff felt that they were not valued by other professional groups. Many staff further stated that their opinions were never asked for from the SMT. A number of ward staff commented about going to MDT meetings but not being asked for a nursing report. One nurse recalled that they had attended a ward round and had read out nursing notes. The rest of the team then discussed the care amongst each other. Their involvement in case conferences were also viewed as being marginalized with a number of staff suggesting that their main role was as a “bouncer” to ensure that the security of the conference was not compromised. The main nursing input to case conferences was to do a summary of current developments. However, the level of involvement and knowledge of the nurse attending the case conference was often a matter of chance. On one ward, Unit A, the inquiry team were informed that if the primary nurse is on duty (from the shift undertaking keyworking) – they would prepare a report for the case conference and attend the case conference. However, if they were not on shift then the CNM2/SCO would attend even though they may not have had any involvement with that patient’s care. Some of the MDT meetings were held in a location away from the ward although it was noted that there was an attempt to hold all the ward rounds on the individual wards concerned. However, at times difficulties with finding suitable facilities (such as rooms that were big enough to hold ward rounds) would result in one big meeting away from the ward and then smaller ward rounds. The ward teams would, often, not be able to attend these big meetings resulting in their input being excluded from the decision making process. There were a number of staff who stated that the fact that individual wards catered for five for six MDT’s meant it was difficult to develop a key working approach and a clear working relationship with a MDT. Within the MDT approach to care, a care co-ordinator was appointed who was responsible for each aspect of care. Due to the lack of involvement in the MDT, ward staff did not act as care co-ordinators again leaving their contribution apart from other members of the MDT. The main MDT care planning tool was the TCP. This was reviewed weekly at the ward round. However, the nursing input was again minimal. There was some suggestion that there was more attention paid to nursing views at the weekly bed meeting although this was only noted by a couple of ward staff.

Ward staff also voiced concerns that there was often no feedback given back to ward staff from case conference/ward round unless major concerns were being expressed. Some ward staff also suggested that some individual members of the MDT did not communicate or interact with ward staff though this was not substantiated by many staff and it seems that this view was not held by the majority of ward staff. The recent changes to the delivery of care on SABU meant that this division between the MDT and ward staff was not that evident on this ward with joint planning of care and support of members of the MDT (specifically the psychology team in helping with dealing with challenging behaviour) to the ward staff both in evidence.

### **Roles**

It was also noted by many staff that ward staff also had very little involvement in therapeutic activities even when these were based on the wards. The view expressed was that the role was mainly custodial rather than therapeutic although a number of ward staff expressed an interest in wanting to be more involved in therapeutic activities. It was acknowledged that there had been some encouragement to do joint groups but that this had not resulted in any real change. It was also stated that on some wards there may be a majority of the patients on a ward at various therapies. However, it was commonplace for ward staff not to stay with these patients unless they were on special observations (or unless it was a female patient). There were also suggestions that ward staff did not value the therapeutic activities (either rehabilitation groups or the various therapeutic activities). A number of MDT staff stated that often staff would not bring patients to appointments or would bring patients late. If someone who was due to take part in a session or therapeutic activity did not arrive, there would frequently be no contact from ward staff. A number of staff recalled ward staff also ringing up to clarify whether a patient should be part of a therapeutic activity and at times this happened when the patient was already there. It was viewed that a lack of continuity of staff on the ward (and of their knowledge of individual patients) contributed greatly to this problem. There were also allegations that staff would interrupt ward based therapeutic sessions and would openly question the need for ward based therapy. Other MDT staff also noted that when doing work in wards there were sometimes problems if ward staff were required to be in the session (for security reasons) and that due to the lack of available staff, sessions might need to be cancelled.

In terms of the nursing roles, many ward nurses complained that they frequently had to undertake what were considered non-nursing roles such as mopping floors, and cleaning dishes. Finally, a number of junior nursing staff commented on the fact there were also no progressive management positions for junior nursing staff (such as a CNM 1 position) so that it was difficult to gain management experience and that opportunities for promotion were also limited. We have been informed that the new model management structure, which was recently accepted by the staff side following a ballot, would include CNM1 positions being introduced into the service.

### **Supervision**

The clinical governance questionnaire stated that the appraisal of staff performance is undertaken through clinical/management supervision. For the other members of the MDT there was a clearly organised system of regular clinical supervision. However, none of the nursing or care officer staff that were interviewed had received any formal clinical supervision. A few ward staff commented that they did have some form of informal supervision at times, but that this was infrequent and was usually in respect of a particular incident. Some staff said that the only time that formal supervision would take place would be if they had “messed up” and was therefore viewed as part of retributive action rather than a method of developing skills and knowledge. Many staff complained of the lack of any effective appraisal system and that there were no personal development plans.

### **Information Sharing**

There were numerous apprehensions expressed about the sharing of information within the wards. Concern were expressed by a number of ward based nurses that there was only a limited amount of consultation about the recently opened Unit B and that their wishes as to the structural environment was not required. They had similar concerns as to whether their views would be taken into consideration in the proposed new development. There were observations made about the dissemination of information to ward staff. A number of ward staff commented that memoranda/draft policies would get sent to the wards but then stay in office draws and not discussed by ward staff. This included recommendations made in the light of untoward incidents. Information sharing between different shifts was also limited with the inquiry being

informed that one ward handover usually took about 5 minutes to handover 16 patients. There was also no evidence of any team briefings on the ward.

### **Training**

There was a general recognition that the training opportunities were of a good standard with a comprehensive induction package as well as good postgraduate training and continuing professional development opportunities. The education and training department were in charge of this and their role focused primarily on the development of nursing and care staff. There were three members of staff and apart from induction, all in-service training and mandatory training were also co-ordinated through this department. One member of staff has a joint Lecturer-practitioner role with Trinity College, University of Dublin. The inquiry was informed that the induction would usually consist of the following: MHA training, breakaway techniques, and an overview of the different services within the C.M.H. The mandatory training for all ward staff includes: challenging behaviour, Prevention and Management of Violence and Aggression (PMVA) techniques, Control and Restraint (breakaway) which includes crisis prevention, basic life support, fire support and drill, and manual handling. The department also runs the full Control and restraint training course and also offers continuing professional development for care officers and nursing staff. The courses on offer were guided by a training needs analysis that had been undertaken by the department. The primary limitation appeared to be that, at times, it was difficult to free ward staff to attend courses.

The department had also accessed the Howard Shore training scheme which has been accessed by the Clinical Nurse Managers. They had also been involved in piloting team working in some wards but this had to be stopped, as there were problems in implementing this amongst some ward staff. There has also been some examination of nursing models, primary care systems, nursing management, and admission assessment though this had not led to these being used formally on the wards.

There was no evidence of any nursing research, or any implementation of evidence based practice, that had been undertaken to develop or evaluate nursing care on the wards. However, there was the opportunity to undertake an MSc at Trinity College,

University of Dublin and that undertaking a research project would be part of the course.

### **Staffing**

The complement of nurses and care officers employed prior to the current capping of the staff budget has been detailed at 166. Of these, 111 would be required to staff the wards. The current cap on recruitment meant that the current establishment of care and nursing staff currently employed is 136 resulting in the need to offer 12 overtime shifts per day. There is also a difficulty in that there is a national agreement not to employ HCA's and that there are problems in changing currently agreed practices. Both senior nursing staff and care officers stated they would welcome discussions on developing health care assistant posts within the service to try and alleviate some of the staffing problems. It was recognised that appropriate training and supervision would have to be in place to these post holders. The staffing levels proposed by the Director of Nursing reflect the figures advocated in the Butler report (1974) with an overall ratio of staff to patients of 2:1. The current staffing levels mean that there are fairly low numbers of staff at night. The clinical governance questionnaire states that this means the focus is on maintaining a secure environment rather than engaging in therapeutic activities. Additional staff were allocated to allow for the practice of slopping out to end. There are also plans for increased staffing at night to increase the patient day till 11pm. At the time of writing this report, there were no clear plans for the introduction of this proposal.

The shift system would also seem not to support the development of a valid and consistent keyworking system delivering a clearly defined model of care as there was little overlap between different shifts to allow for a clearly agreed care planning strategy and a consistent approach. This was clearly documented in the discussion paper "Introduction of Ward Management into the C.M.H." that was put forward by the Director of Nursing in November 2005. The limitations of the current shift system were noted as:

- Lack of communication between opposite shifts.
- Lack of continuity of care.
- Varying standards of care.

- “Gatekeeping” role as opposed to a management function.
- Little interest in strategic development of unit or ward.
- Difficulty in implementation of change across the hospital due to numbers of staff involved.
- Derogation of responsibility i.e. blaming the opposite shift when things go wrong.

The practice of central rostering also meant that people were frequently moved to cover wards and that there was often no continuity in the staff allocated to individual care settings. The Principal Care Officer group indicated that usually 50% of the ward staff were not on the designated shift. An example given to the inquiry team was that a keyworker system was being introduced on Unit B. However, there were only 5-6 members of staff who would be regularly rostered on to that ward. Consequently the potential for consistent care to be offered to the patients was severely reduced. They further suggested that dedicated core staff allocated to a specific ward (or clinical area) would be a good idea.

### **Community Psychiatric Nurses/Clinical Nurse Specialist**

There are six Community Psychiatric Nurse’s and one Clinical Nurse Specialist (dual diagnosis) who are employed by the service. Each CPN undertakes in-reach work within an assigned prison while some also have a liaison role with services in local area regarding discharge. The clinical nurse specialist works specifically in developing interventions, and giving advice, with regards dual diagnosis patients. Pre-admission assessments are undertaken by community psychiatric nurse’s as well as a Psychiatrist and fed back to the pre-assessment meeting. Each Community Psychiatric Nurse is also a member of a specific MDT and attends weekly ward rounds and case conferences as a member of that team. There are also plans to develop an advanced nurse practitioner to develop this role. They have ongoing involvement with patients through their membership of the MDT and their notes are kept as part of the Multidisciplinary team notes. They all have regular clinical supervision on a fortnightly basis from one of the Assistant Director’s of Nursing. At present the Community Psychiatric Nurses are involved in in-patient work on admission and prior to discharge. However, they informed the inquiry that they were developing a long

term relapse prevention group which would last for twenty eight weeks. They were also in the final stages of developing a shortened version of this group to start on Unit B which would last for six weeks.

### **Nurses from Ethnic Minority Groups**

The inquiry was informed that there were a number of nursing staff who had been recruited over the past few years and who were of African or Indian origin. However, there were no accurate figures recorded by the service as to how many were from an ethnic minority staff. There is an overseas nurse's induction procedure and the dignity at work policy clearly documents the non-discriminatory nature of the service. There was some suggestion from one member of this staff group that they were more likely to be ridiculed and to be given less co-operation from other ward staff members. It was noted that there was currently no diversity training within the service and also that a recent national study had shown that overseas nurses were often recruited without knowing which clinical (or geographical) area they were going to work. The service have indicated that they are aware of this problem and are communicating with the HSE Dublin Mid-Leinster (East Coast Area health Board) with regards to this.

### **FINDINGS-NURSING AND CARE OFFICERS**

- 1. The Inquiry Committee found that, due to shift system of staffing the wards, there is little continuity of care. The Inquiry Committee notes that there are advanced plans to introduce a ward management system. This proposal has been agreed following a ruling at the Labour Relations Court.**
- 2. There is no key working system in the Central Mental Hospital. In addition, different wards that have introduced key working have used different models.**
- 3. There is a shortfall of nursing staff due to the employment ceiling. This results in the reliance on overtime to allow the wards to be adequately staffed.**
- 4. In most wards nursing care plans were not up to date and progress notes bore little relationship to care plans.**



5. **Ward staff are not actively involved in therapeutic activities. It was reported that on occasions some ward staff encourage non co-operation in the therapeutic activities.**
6. **Many ward staff do not view themselves as part of the MDT. Separate care plans, and lack of ongoing communication enhances this view.**
7. **The ward staff on SABU are the most integrated in terms of working collaboratively with other members of the MDT. They are also the most positive about MDT working. It is also the only unit within the service that has a dedicated MDT for one ward.**
8. **There is a lack of knowledge of educational opportunities for care officers with regards working in a primary care role on the ward.**
9. **Staff development opportunities are good.**
10. **There is a perceived poor communication of information filtering down from the Senior Management Team and from case conferences.**
11. **The CPN group have a close working relationship with a dedicated MDT team and also receive regular clinical supervision**
12. **There appears to be very little (or no) research nor practice development undertaken by ward staff**
13. **There is no monitoring of ethnic minority ward staff nor any diversity training**
14. **The participation of service users in their care plan is haphazard**

#### **RECOMMENDATIONS-NURSING AND CARE OFFICERS**

1. **The process of central rostering procedure should be reviewed. A system whereby dedicated ward staff are allocated to individual wards, or specific areas such as admission, medium secure care or rehabilitation.**
2. **A keyworking system needs to be developed and introduced to all wards using the same model of care**
3. **The employment ceiling should be rescinded**
4. **Nursing care plans should be regularly updated with audits undertaken on a periodic basis to ensure this occurs**
5. **Ward staff should be encouraged to develop therapeutic roles within the ward and to participate in developing therapeutic activities/groups with professional colleagues**

- 6. All ward staff should receive regular clinical supervision**
- 7. The service should examine ways of ensuring that ward staff are more firmly integrated with MDT's. This could be through dedicated MDT's for each ward, or into specific clinical areas (admissions, medium secure care, and rehabilitation).**
- 8. The nursing care plans and TCP's should be combined into one overall care plan.**
- 9. Care officers should receive training and support in primary care working**
- 10. The policy regarding the dissemination needs to be reviewed and replaced with a more effective procedure**
- 11. It would be beneficial for the CPN group to have formal links with ward nurse managers to enhance professional development and support**
- 12. The service should encourage ward staff to undertake research and practice development projects**
- 13. There needs to be monitoring of ethnic minority staff and diversity training**
- 14. Service users should be involved in the development of their care plans and this formally recorded. Where this does not take place, the reasons should be documented. This should be regularly audited.**

## **CATERING MANAGER**

There are deficits in the area of occupational therapy in assessment and developing competency of activities of daily living of patients, due to the unavailability of kitchens. Although kitchens were available on some wards, but occupational therapy staff had been precluded from working with patients in these areas, by the catering manager due to her responsibility in food handling and management of the kitchen facilities. The inquiry was given to understand that the MDT did not address these concerns and remains an organisation impasse.

The catering manager stated she was unaware of any discussions that had taken place regarding this issue and that she was unaware of any forums between the Senior Management Team, occupational therapy and the catering department to address this issue. She suggested that a working party should be established to resolve the current situation.

The catering manager stated that there is scope for the catering department staff to be involved in ADL programmes, as this is their area of expertise. Currently the department are introducing healthier options for the patient's diet. The catering manager was not aware of any discussions or concerns about the time of the evening meal and the lack of provision of a supper on the units. Staff are rostered to work until 19.00hrs and could provide supper providing it was appropriately stored on the units.

The catering manager reported that the cleanliness of unit based facilities was beyond her remit as was checking the temperature of food on the units. She stated that she has reported environmental health issues to the hospital manger and said that these issues have not been resolved. The hospital is subject to an annual environmental health examination. The catering manager reports to the hospital manager.

**FINDINGS-CATERING MANAGER**

- 1. The Inquiry Committee found that the absence of assessment kitchens for occupational therapy programmes limited rehabilitation.**

**RECOMMENDATIONS-CATERING MANAGER**

- 1. The issue of providing ADL kitchens for basic occupational therapy and rehabilitation must be addressed.**

## **THERAPEUTIC ACTIVITIES**

There are a number of off ward activities available for the service users. They include education, industrial therapy and horticulture. It was recognised that the horticulture activities offers the service user the ability to learn new skills and the department should be commended for the high standard for the gardens within the hospital. The education department offers a range of courses at different levels of attainment and the staff were supportive and positive about creating learning opportunities for the service users. The industrial therapy department offered task based work which did not appear to be based on the needs of the service users. There is a need to balance the therapeutic needs of the service users with appropriate activities based on individual care plans. There is also a community day facility in Usher's Island. At Usher's Island the service users have the opportunity to partake in activities away from the hospital. Access to these activities is determined by the multidisciplinary team (MDT) and subsequently the availability of ward based staff to provide escorts.

There are minimal therapeutic activities for service users on the units. Unit B has recently started an art group. It was reported that the occupational therapists (OTs) and psychologists have made attempts to implement groups on individual sessions on the units. However the groups are often cancelled by ward based staff due to staff shortages or the groups are interrupted.

It was reported that the lack of regular unit based staff has hindered the implementation of group programmes. The central rostering and rigid shift system does not allow for continuity of staff and therefore planning therapeutic group programmes is hindered. The absence of a keyworker system also hinders the process.

Another factor is the lack of physical resources in the units, lack of facilities to undertake assessment of daily living skills and no central area within the hospital to facilitate therapeutic group programmes.

## **FINDINGS-THERAPEUTIC ACTIVITIES**

- 1. There are a number of different off unit activities for patients**
- 2. There are very few unit based activities for patients unable to leave their units**
- 3. Attendance at therapeutic activities is sometimes hindered by staffing difficulties such as central rostering, shift system, and lack of keyworker.**
- 4. There is no centre for full assessment of Daily Living Skills.**

## **RECOMMENDATIONS –THERAPEUTIC ACTIVITIES**

- 1. There should be unit based activities for patients unable to leave the units, based on patients individual care plan**
- 2. Patients should be able to attend therapeutic programmes, groups and activities whenever scheduled. This should be facilitated by unit staff and a key worker system**
- 3. There should be a dedicated daily living skills area where assessment and therapy can take place**

## **VOCATIONAL OFFICERS**

Activity Programmes include education, woodwork and horticulture. These programmes are provided by vocational officers. The horticultural programme looks after the grounds of the hospital as well as providing training in horticulture and uses a mentoring system by other patients. There are approximately 25 patients attending this programme, 5 of whom attend for recreational purposes.

Patients may also attend industrial therapy. Those attending industrial therapy regularly receive a payment at Christmas time. As patients attending vocational training do not receive this there is an incentive to attend industrial therapy rather than vocational training.

All patients have a separate risk assessment carried out by the vocational officers following referral to the activity programme.

Women patients are not allowed to attend the vocational activities unless accompanied by a female member of staff. As female staff are not always available, women patients are not regular attenders. They may attend industrial therapy as there is a female member of staff managing this area.

There are difficulties throughout the hospital in patient's attendance at the activities. Often vocational staff must ring to remind ward staff to bring patients down and they often attend late. According to vocational staff some ward staff appear to be unaware which patients are supposed to attend, although there are notice boards with patients timetables on the wards. Escort duty can sometimes cause staff difficulties resulting in patients not attending their activity programme.

### **FINDINGS-VOCATIONAL**

- 1. The Inquiry Committee found that there are difficulties in women patients attending vocational activities.**
- 2. The Inquiry Committee found that patients sometimes did not attend vocational activities due to lack of adherence to a patients individual care plan.**
- 3. The Inquiry Committee found that there was an incentive to attend industrial therapy through money payments, rather than attending vocational activities.**

### **RECOMMENDATIONS-VOCATIONAL**

- 1. Women patients should have opportunity to attend vocational activities**
- 2. Patients care plans should be followed in respect of therapeutic activities. Reasons for not adhering to care plans should be recorded.**
- 3. The issue of payment exclusively for industrial therapy should be reviewed.**

## SECTION 9- USERS AND CARERS

The definition of what constitutes a carer is regarded as any relatives or informal carers of a patient residing at the Central Mental Hospital. There are two formal groups for carers at the Central mental Hospital. The first group is supported by the Social Work department and Schizophrenia Ireland functions as a pressure group to improve conditions and treatment within the service. The second group is also supported by the social work department and its primary function is as a support network for members to the group.

The views of carers were obtained during two group meetings held with the inquiry team. Representatives of both carer groups participated in these meetings. In the first group, a representative from Schizophrenia Ireland was also present. Postal correspondence was also submitted by members of this group.

A wide range of issues were brought up by carers and the main themes are noted below. There were widely different views on the quality of the service offered and the relationship between the service and carers. Some carers were highly critical while others praised the quality of the service.

### **Interaction with Staff**

#### **Information**

There was a general consensus that interactions with staff were infrequent and usually associated with limited information being given to carers. However, there was an acknowledgement that since the social work team have been developed, the level of information that carers received had improved. Several carers also reported that they had been able to start to form relationships with specific members of staff for the first time and noted that a number of initiatives had been developed over the past couple of years including carers being given an escorted visit of the wards, and support for the two carers' groups. Carers generally saw this as a positive move though there were still many aspects of the service that they perceived to be shrouded in secrecy. Several carers noted that they were not informed by the service that their relative/friend had been admitted to the Central Mental Hospital including one family who reported only finding out after the patient had been at the CMH for four months following transfer from prison.



### **Visiting**

Most carers' initial face to face contact with the service occurred when they came to the hospital to visit their relative/friend. The carers' visiting hours are between 1.45pm and 3.40pm every day except Thursday when there is an evening visiting period which must be booked in advance. At present three people can visit for a period of two hours on one occasion per week. Most of the carers at the meetings were of the opinion that there were concerns with the way in which carers were received when attending for a visit. One visitor was unable to see a family member after a long journey as the patient was secluded, and recalled being given a short statement from staff to the effect that they could not see their relative. Other carers also noted that they did not consider that staff took the time to speak with the relative and address any concerns. Another relative reported that four of the family had travelled from Limerick by public transport to see their relative and were unaware of the maximum number of visitors allowed at any one time. They then had to visit in two groups of two whilst the other two carers waited outside the hospital gates in the rain. It was reported by staff that a waiting area is available at the gate. Additionally relatives are not usually allowed to visit patients on wards apart from Unit A (women's service) and the hostel ward. If their family member is unable to attend the visiting hall they reported being told at the gate that the visit was cancelled and given no further information. However the Inquiry committee have been informed by the Clinical Director that Unit B has facilitated visiting on the ward on several occasions over the last year when a patient was too unwell to leave the ward. There was also concern expressed with the fact that food, clothing, and other items are left at the gate as they needed to be screened before being given to the patients. Carers reported that some patients had not received these items with the view being that staff mislaid them.

### **Care Planning**

It is hospital policy to invite and include carers in the decision making process at case conferences. However, the majority of the carers stated that they did not feel that they were able to contribute to the case conferences in a meaningful way and that were not part of the decision process. Another common perception was that carers stated they were being informed of decisions rather than being a part of the decision making

process. Other carers felt that the case conferences were too big with up to 15 staff and they felt too intimidated to contribute. This was enhanced by the fact that on several occasions carers were not informed who all the members of the case conference were. Many carers noted that a major difficulty in being able to discuss care and treatment issues with staff at the hospital was a lack of primary nursing staff. Carers noted that they would often meet up with different staff on each visit and that no-one was consistently involved with the patient to be able to discuss a patient's progress with the carer.

A number of carers also expressed concerns about medication and about side effects including drowsiness and weight gain. Upon further discussion, it appeared that there had not been the opportunity for most of the carers to discuss issues surrounding medication with the clinical team which had resulted in their concerns continuing.

### **Discharge**

A number of carers complained that they were not part of the discharge process and that they had no contact with members of staff prior to the discharge of their relative it is possible that in this instance the family member had been return to prison first. There were concerns about the aftercare that some patients received on return to their own mental health service. The biggest issue raised, however, was the lack of knowledge they had about the plans for discharge, and uncertainty about their role within the discharge process. Other carers spoke highly of their contact with the social work department especially those involved in the carers' group.

### **Security and Culture**

Some carers stated that they viewed the hospital regime as similar to that of a prison whereas others appreciated the need to ensure the safety and security of the patients and staff and visitors. They felt patients were treated like prisoners adding that staff used prison language and that patients felt they were in prison. Some spoke of the security resulting in the lack of privacy and carers feel that there is an over-emphasis on security within the C.M.H. The group said it had been the case that letters were read before they are sent out and sometimes stamped "C.M.H." and that more recently letters have been sent out unopened which has been welcomed. The carers group felt that the unit based staff carried the culture of the hospital and that other professional groups were obliged to go along with it.

### **Coercion**

A number of carers brought up the view that they had been requested by patients at the CMH not to complain about the service as if they said anything about the service, this would have a negative impact on their care. Although no evidence was put forward to support the view that the patient would be treated unfairly, this was a wide spread assumption within the carer group and they described that intimidation was mediated through a look, a change of tone or not paying attention to the patient. The limited discussion areas of concerns to members of the service meant that carers were dissatisfied with the care their relative/friend and concerned about the perceived coercive nature of the service.

There were some views expressed that seclusion was used as a punishment and that patient had been threatened with physical assault. However, no specific allegations were made by the carer's group nor was there any evidence to substantiate these views. This view was only noted in one of the carers meetings with the other meeting assuring the Inquiry Committee that they had not received reports of allegations of physical or sexual abuse. It appears that a lack of knowledge of the service and its procedures may have contributed to this view being held by some carers.

### **Complaints**

Few carers had officially complained to the service about the care received by their relatives/friends. However, of those that did, there was a mixed reaction. One carer noted that they had received a letter back acknowledging the complaint, although nothing further had happened so far. Another carer described how they had not received any reply to two letters of complaint and recounted feeling as though the service did not care for her or her relative in their care.

### **Environment**

A number of concerns were raised about the environmental features of the hospital. There was concern about the condition of the building and particularly the use of metal shutters on Unit 2. Unit 3 was described as too warm and that windows can't be opened. The effect of this on the patients was that the rooms were perceived as airless and excessively warm during the summer months. There was also a perception that the heating remained on during warm weather. Concerns were also expressed about

the beds with these described as being formed of concrete with a mattress on top. The poor standard of cleaning of the wards was also criticised.

### **Fire Safety**

Carers were worried about fire safety especially as patients are locked in their rooms at night and that there has been no fire drill with patients.

### **Locking in rooms at night**

The interviews with the carers coincided with the time when the practice of “slopping out” was being stopped. Many carers voiced concerns about both the need to lock patients in their bedrooms at night and also the time it took for staff to unlock doors for patients to go to the toilet.

### **User Views**

The user views in each individual ward are detailed in the descriptions of these units. (Sections 4 and 5). In addition, a survey was undertaken to assess overall levels of patient satisfaction of the service using the Forensic Satisfaction Scale. The scale has eight sub-scales as well as a total score. All questions ask the respondents to rate their level of agreement on a five point likert scale. Higher scores reflect greater levels of satisfaction with the mid point score being three. For more details about the measurement scale, please see Appendix 3. The inquiry was aware that the service indicated in the clinical governance questionnaire that a patient satisfaction survey had been undertaken in 2005. However, despite a request for information about the survey, no information was forthcoming from the service.

**USER SATISFACTION**

Table 9-1. Total scores on the Forensic Satisfaction Scale for each unit at the Central Mental Hospital

Name of Ward	FSS Total Score (sd)	One sample t-test (sd)	P Value
Ward A	2.71 (0.42)	-1.66	0.15
Ward B	3.55 (0.16)	8.38	0.00
Unit 2	3.16 (0.53)	0.84	0.43
Unit 3	3.29 (0.35)	2.34	0.06
Unit 4	3.09 (0.38)	0.34	0.79
Unit 7	3.52 (0.39)	2.66	0.08
Hostel	3.31 (0.71)	0.97	0.39
Total	3.23 (0.49)	2.93	0.01

During the course of the inquiry thirty-nine patients at the Central Mental Hospital completed the Forensic Satisfaction Scale and the results are presented in Tables 9-1 and 9-2. This number reflects 51.32% of the patients within the Hospital. It is acknowledged that the non-respondents may have different opinions about the service than those who responded but we can state that the percentage of respondents was similar in all of the different clinical areas and at the very least the results can be viewed as giving a general overview of the perceptions of the service by the patients.

The total score for the CMH was 3.23 and was statistically significant when analysed using a one sample t-test against a mid point score of three. This suggests that the patients tended to be satisfied the service. Similar surveys in three medium secure units in the UK produced scores of between 3.02 and 3.54 suggesting that the level of satisfaction was similar for patients within the Central Mental Hospital. When examining the individual ward scores, all of the wards surveyed, apart from Unit A, scored above the mid point score suggesting that in these wards the patients were generally satisfied overall with the service provided. Although one sample t-test analyses were undertaken, the low numbers of respondents in each unit mean that the statistical significance needs to be viewed with caution. Unit B did record a high score of 3.55 and was statistically higher suggesting satisfaction with the care provided in

the ward. Only one recorded a level of satisfaction below the mid point score. In Unit A (the women’s service) a score of 2.71 was recorded suggesting some dissatisfaction with the service provided. All of the sub scale scores were below the mid point score apart from safety and rehabilitation suggesting that the women felt safe on the unit and were that they were accessing therapeutic and social activities that they perceived as helpful for when they would be discharged. However, concerns about communication and information sharing, finance, being treated differently to the male patients, the unit environment and interaction with staff were all viewed negatively.

Table 9.2 – Forensic Satisfaction Sub-Scale Scores at the Central Mental Hospital

Sub Scale Score	FSS Total Score (sd)	One sample t-test	P Value
Communication	2.91 (0.65)	- 0.92	0.37
Finance	2.75 (0.86)	-1.74	0.09
Gender	3.02 (0.87)	0.71	0.87
Milieu	2.95 (0.63)	-0.43	0.67
Overall	3.23 (1.21)	1.20	0.24
Rehabilitation	3.39 (0.55)	4.41	0.00
Safety	4.10 (0.55)	12.41	0.00
Staff Interaction	3.40 (0.65)	3.89	0.00
Total	3.23 (0.49)	2.93	0.01

Table 9.2. records the subscale scores for the hospital, as well as the one sample t-test relative to the mid point score. It shows that five of the sub scale scores are above the mid point score and three are below. The three subscales below the mid point (thereby expressing some dissatisfaction with that part of the service) are communication, finance and gender. However, none of these scores is statistically significant although there is a tendency towards significance in the finance score suggesting that there is some level of concern about the lack of advice and assistance surrounding financial support. In relation to the five sub scales (overall care, milieu, rehabilitation, safety and staff interaction) these suggest a mainly positive view of these aspects of the service and in the case of rehabilitation, safety and staff interaction issues, these were all viewed as statistically significant. The score of 4.10 for the sub scale of safety

suggests that the patients were are highly satisfied with the lack of personal threat to their person within the service.

#### **FINDINGS-USERS**

- 1. The inquiry was unable to ascertain when patient satisfaction had last been assessed by the service nor the results of this assessment.**
- 2. When undertaking the Forensic Satisfaction Scale, the users of the service indicated that they were generally satisfied with the service received.**
- 3. Only one unit (Unit A) recorded dissatisfaction with the service.**
- 4. Within the eight subscales examined by the satisfaction scale, the majority recorded levels above the midpoint score indicating satisfaction with the service.**
- 5. Three sub-scales scores were below the midpoint score and one (finance) recorded a score that was some way below the mid-point score.**

#### **RECOMMENDATIONS-USERS**

- 1. The factors surrounding the dissatisfaction reported in Unit A needs to be examined by the service. This is discussed in more detail in Section 4 of the inquiry report.**
- 2. There is a need for an examination of the financial difficulties that patients face and the assistance given to patients that may be experiencing financial difficulty.**
- 3. A regular assessment of patient satisfaction should be undertaken. If possible this should be done on a yearly basis with areas of dissatisfaction identified and remedial action undertaken.**



## **FINDINGS – CARERS**

- 1. There were differing opinions from carers as to the quality of the service in the Central Mental Hospital ranging from those that viewed the service in a positive light to those that had negative opinions of the service.**
- 2. It is acknowledged that great strides have been made in developing contacts and working with carers during the period of the inquiry, especially from the social work team.**
- 3. There have been recent positive developments with regards to the development of carer services. Two carers groups are functioning well and Schizophrenia Ireland are supporting carer developments in the service.**
- 4. The service detailed a number of proposed developments concerning carers in its clinical governance questionnaire that carers would be members of a proposed advisory board for the service and to have a greater role in reviewing policies.**
- 5. There are still a number of strongly held views held by carers concerning the perceived restrictive nature of the service, its prison-like mentality, and its coercive nature. We did not find that these practices were current at the Hospital.**
- 6. The inquiry was of the opinion that the service did not effectively communicate with carers on a consistent basis. This lack of communication had allowed a number of carers to develop the view that the service was hostile to them and to the patients.**
- 7. A number of carers had no regular contact with any member of the service.**
- 8. Carers were sometimes not being given clear information about the progress of the patient especially during the initial admission phase.**
- 9. There were occasions where carers were not aware of who was part of the patients care team. This would lead to carers not being aware of whom to approach or talk to about the care and treatment of the patient. This was especially the case when visiting the patient or when phoning the ward.**

- 10. Carers sometimes felt intimidated by case conferences due to the large number of staff present (many of them who were unknown to the carers), uncertainty about their role within the case conference, and a sense that they were unable to participate in these discussions as decisions about care had already been made beforehand.**
- 11. There was a limited involvement in any pre-discharge planning for a number of carers. Some carers had spoken of not being aware when patients had been transferred back to prison, or had been discharged into the community.**
- 12. There were limitations in the number of carers that were able to visit a patient at any one time. In addition, the visiting time was only for a limited periods. The inquiry were aware that some carers had travelled long distances to visit the patients and the visiting policy meant that either some carers were unable to visit the patients or that the amount of visiting time had to be divided to allow all carers to visit in the allotted time.**
- 13. All visits were held in the visiting hall and not in the patients' wards (apart from those patients in the Hostel ward). This did not seem to be based on individual risk. It also resulted in limited contact between ward staff and carers.**
- 14. The response of the service to complaints made by carers was variable.**

## **RECOMMENDATIONS- CARERS**

- 1. The positive developments made in developing the two carers groups and the input of Schizophrenia Ireland are welcomed and would encourage these being continued and expanded.**
- 2. The inquiry supports the proposal noted in the clinical governance questionnaire that carers be invited to participate in the proposed advisory board for the service and have a greater role in reviewing policies.**
- 3. There should be a dedicated named member of the service who has ongoing contact with the nearest relative or carer of each patient admitted to the Central Mental Hospital throughout their stay at the Hospital. This member of staff should be part of the patient's care team.**
- 4. These dedicated staff members need to be clearly identified to the carer as part of the admission process.**
- 5. Carers should be regularly updated on the care and treatment that the patient is receiving (subject to the patient being agreeable to this).**
- 6. Carers should be informed of the names of those staff that are part of the patients care team.**
- 7. Members of the ward staff who are part of the care team should be identified to carers.**
- 8. The needs of the carer should be when attending a case conference. This should include:**
  - a) Ensuring that the majority of staff present at the conference are known to the carer**
  - b) That a named member of staff be assigned the role of "supporter" to the carer.**
  - c) Providing carers with an overview of the nature, role, and procedures of a case conference**
- 9. The number of carers/family members who can visit at any one time (and the specified visiting times) should be reviewed. Special consideration should be given to those carers who have travelled a long distance.**
- 10. Consideration should be given as to whether patients (particularly on Unit 3 and Unit 7) should also be allowed to have visits on the ward. This**

**consideration should be based on individual risk factors rather than a blanket rule.**

- 11. The service should ensure that carers are clearly involved in any pre-discharge planning unless there are exceptional circumstances which would make this unreasonable.**
- 12. Any formal complaints made by relatives should be acknowledged within a two week period of receiving the complaint. Responses to the complaint should be made within a three month period (unless in exceptional circumstances and this should be relayed to the carer). This should be audited.**

## SECTION 10-ORGANISATIONAL ISSUES

The Inquiry was not in a position to review all relevant organisational issues as part of the process of reviewing working practices with regard to care and treatment but focussed on clinical governance structures and considered support structures, working relationships and industrial relations where these were felt to have an impact on patient care.

### **Strategic Priorities for the C.M.H.**

The broad management team had identified the following areas of development as their immediate priorities and were working on the implementation of these priorities during the course of the Inquiry. Areas identified were as follows:

- Establishment of six low support community placements for discharged patients with assertive outreach services provided by community staff from the Central Mental Hospital.
- To end ‘slopping out’ throughout the hospital.
- Establishment of a nurse-led ward management structure.
- To further progress the development of key/primary nursing models of care on wards.
- Development of ward based therapeutic activity programmes, particularly on admission wards.
- To provide primary care clinics for inpatients.
- Appointment of a General Manager to complete the tripartite management team.
- Implementation of the 2001 Mental Health Act.
- Implementation of ‘A Vision for Change’ report.
- To further develop the system for patient centred contracts with their catchment area service prior to admission with a view to fostering recovery.
- To carry out a full options appraisal of patient accommodation and other facilities with a view to increasing bed capacity to meet known unmet need.
- To prepare for the commencement of the Criminal Law (Insanity) Act, 2006.

- To further develop formal structures for carer and user involvement in service development, planning and quality assurance.
- To establish patient kitchens on Units 3, 7, the hostel and unit A for training purposes and quality of life improvement.

Priorities achieved during the year of the Inquiry included the ending of slopping out, the appointment of a General Manager and work in relation to the implementation of the 2001 Mental Health Act and Criminal Law (Insanity) Act, 2006. There has also been impressive continuing work in developing partnership working with housing associations, children and family services, social welfare services, prison services and gardai at all levels. Progress has also been made in other areas including the development of some ward based therapeutic activities and of enhanced community support for discharged patients. Strategic priorities over the next three to five areas have been identified as follows:

- Development of a modern, fit for purpose hospital building.
- To develop the service to meet the Service Level Agreement with the Irish Prison Service/Department of Justice, Equality & Law Reform such that prisoners can be transferred for urgent treatment in a timely manner.
- To further develop a diversity of community aftercare structures and placements for mentally disordered offenders including extending use of the Usher's Island service.
- To enhance and develop the service's advice and support role with local mental health services.
- The development of women's services.

### **H.S.E. Interface**

The Senior Management Team reports to the local health office manager with responsibility for mental health. Mr. Jim Breslin has had responsibility since June 2005 in a regional role within Dublin Mid-Leinster. He also has a national brief to oversee the National Forensic Service focussing on policy in the area and strategic development. The future of the hospital site was discussed at the Inquiry Committee's meeting with representatives of the H.S.E. when it was stated that a

decision from the government as to the site for relocation of the hospital was imminent. It was subsequently announced that the hospital will be built adjacent to the new prison replacing Mountjoy in Thornton Hall, Co. Dublin. The H.S.E. had submitted their views to the Government but were aware that they only had a consultative role in respect of this decision. It was acknowledged that a management structure to facilitate the project needed to be put in place. An estimate of 6 - 12 months for planning permission was given although considerable infrastructure will be in place before the start of building work on the hospital having been completed for the prison project. It is estimated that it will take around 5 years to complete the relocation.

### **Co-ordination and Support of Strategic Priorities**

Concern was expressed by the broad management team and many staff that strategic priorities were not supported in a planned way by the H.S.E.'s engagement in the process and in turn that the C.M.H. and H.S.E. did not appear to be integrated into the decision making of relevant government departments. The senior management team were of the view that they were not supported by a line management route whereby they could influence more central strategic and operational decision making to be sure that their views were taken into account. One example reported to the Inquiry was that the decision to relocate the hospital to the Thornton Hall site was taken without significant consultation with the senior management team and a full option appraisal. Many staff and carers heard about the decision on relocation on the radio and absence of communication in this area appeared to undermine the work of the senior management team.

### **FINDINGS- ORGANISATIONAL ISSUES**

- 1. A range of achievements have been secured over the past two years including continuing development of the service to prisons, close working with users and carers and the opening of the new admission ward.**
- 2. The interface between the senior management team, the H.S.E. and central government departments does not appear to support coherent strategic decision making and appropriate communication of key issues. This has a significant impact on staff and patient care.**

3. **The management workload for the senior management team is considerable and a significant proportion falls on the Clinical Director who has extensive clinical commitments. The recent appointment of a hospital manager will strengthen the management team.**

#### **RECOMMENDATIONS-ORGANISATIONAL ISSUES**

1. **The H.S.E. should review the process of strategic decision making in relation to the C.M.H. and secure proper engagement of the senior management team and central government departments in working together on key issues.**
2. **Following the appointment of the general manager the workload of other members of the senior management team should be re-organised bearing in mind the wide responsibilities of the Clinical Director.**



## SECTION 11-HUMAN RESOURCES

### Workforce Issues

#### **Recruitment and Retention**

Recruitment is organised centrally for the whole H.S.E. area through a recruitment agency and recruitment of nursing staff in particular remains very difficult. Clinical Psychology and Occupational Therapy also reported that sustained effort was required to ensure recruitment. Centralised recruitment is seen by the Senior Management Team as not supporting the specialist requirements of the service at the C.M.H. A growing percentage of nursing staff are recruited from India and South Africa and most do not have experience of specialist forensic nursing practice. Human Resources confirmed that these staff are initially employed on temporary contracts. The Inquiry Committee was informed by nursing staff on several occasions that this arrangement means that new staff are inhibited from challenging historical modes of working.

The C.M.H. was traditionally staffed by care officers, however no new care officers have been employed since 1992 and all vacancies are filled by nursing staff. There are currently 47 care officers still in post. The care officer contracts were similar to nurses but have not been reviewed since the introduction of nurses into the C.M.H.

The nursing role has evolved within the C.M.H. since 1992. In 1999 the C.M.H. developed the role of the Clinical Nurse Manager 2 (CNM2). The CNM2 works opposite to a senior care officer, each having responsibility for a shift of duty with staff working a “two day on two day off” shift system. In the absence of a CNM2 on the shift, qualified nursing staff are under the management of senior care officers, who in the majority of cases have no nursing background. Currently there are no CNM3 or CNM1 posts.

The employment ceiling placed on public services by the government has had a significant impact on the service. At the time the ceiling was introduced some 30 nursing posts were lost due to the vacancy factor at the time. It was stated that the

service needs to employ 111 staff to effectively staff all units. Currently the average staffing shortfall is twelve per day which is covered by overtime. The C.M.H. has a history of conflict in the area of industrial relations. It has been reported by both management and trade unions that relations have improved. However there remains a concern from management that if the goodwill of the staff to cover overtime was withdrawn then the service would not function. It has also been widely reported by management that they have fears that strike action may be invoked if relations deteriorate. This is an unhealthy culture to manage a service with these threats in place. It was strongly emphasised by management that the service needs a more robust line management structure within the clinical areas and it is hoped that the proposed introduction of ward managers will provide this structure.

The Director of Nursing reported that he is constrained in being able to develop a balanced workforce by the industrial relations framework of the H.S.E., Irish mental health services and local issues at the C.M.H. The national recruitment ceiling has led to a heavy reliance on overtime. It was also reported that health care assistants cannot be employed despite their important contribution to the skill mix in forensic psychiatric services outside Ireland. In addition union and labour court agreements from the past prescribe the ratio of nurses to care officers. The situation whereby nursing staff are managed by care officer staff remains problematic.

An induction programme is provided for new staff and a retention programme for nursing staff includes provision of a forensic allowance on completion of further training. There are no exit interviews provided due to lack of resources.

### **Proposed Changes in Ward Management**

The Director of Nursing (D.O.N.) has developed a proposal to reform the nursing/care officer management structure which is currently going through the Labour Court. The proposal is to introduce ward managers to each unit. The ward manager would have a defined management role within a specific unit. It is envisaged they will provide strategic and clinical leadership and direction for their unit. The ward managers will report to Assistant Directors of Nursing (A.D.O.N) and ultimately to the D.O.N. The proposal also outlines the development of 16 Team Leader posts at a Clinical Nurse Manager 1 (CNM1) level. The team leader will have

day to day operational responsibility for the unit and will act under the guidance of the ward manager. The proposal earmarks the provision of nine ward managers, one for each unit, including the hostel and two night positions.

The proposed ward management structure will secure ward managers at CNM2 level working to a team leadership structure divided between nursing staff and care officers. The ward manager will have a defined leadership role with delegated responsibilities from the Director of Nursing and ensure the implementation of key working.

### **Change Management**

The Human Resources Department and the Senior Management Team were concerned about the resistance to the implementation of most change initiatives within the C.M.H. Human Resources considered that this resistance is mediated by unions representing unit based staff and the inquiry committee was informed that working with staff-side representation at the C.M.H. is problematic. Two unions, the P.N.A. and S.I.P.T.U. represent the majority of ward staff, S.I.P.T.U. representing care officers and some nursing staff and the P.N.A. representing the remainder of the nursing staff. These two unions have not met together with management and strategic change involves a series of separate meetings. A Partnership Committee has been set up to develop a joint way of working. Modernisation of working practices to improve the flexibility of the workforce that better meets the needs of patients is invariably met with resistance although it was not clear to the Inquiry Committee whether this resistance is truly representative of the views of the majority of ward based staff or is furthered by smaller groups of staff. The H.R. Department and H.S.E. management made it clear that the rigid manner of approaching change and the lack of joint meetings with unions and management has hindered mutually agreed strategies for organisational development.

A development programme during 2002 led to a range of low key issues being resolved and additional staffing secured. Human Resources also considered that a recent joint referral to the Labour Relations Commission with regard to the proposed ward management structure would proceed satisfactorily. Human Resources is aware of the importance of empowering ward managers to implement change. The heavy

reliance on overtime linked with the national recruitment ceiling was felt to be of concern as withdrawal of overtime has the potential to be used by the unions in an unhelpful way at an early stage in the negotiation of change.

One recent example of the impact of I.R. on changes in working practice concerned a response to the Clinical Director on the issue of reading patients' letters prior to despatch. The Clinical Director had sought legal advice as to whether the continuation of this practice in blanket form would be upheld in law. The organisation had received legal advice that continuation of the practice could not be supported and an appropriate policy had been developed to address the risk management aspects of this change in practice. The Clinical Director had received a response from one of the Unions which stated that its members had been advised to continue the practice pending further consultation with no apparent consideration of the risk to the organisation or individual members of staff not acting in accord with the new policy. The Clinical Director informed the Inquiry that on this occasion this did not impede implementation of the policy.

### **Anti Bullying and Harassment Procedures**

The Dignity at Work policy sets out how employees are protected from bullying, harassment and sexual harassment. Support contact people are available for confidential discussion and a matter can be referred for mediation if appropriate and where intervention of a line manager has not led to resolution. Copies of an explanatory leaflet on the policy and contact persons are available at the C.M.H. The policy has only recently been developed in this form. The Senior Management Team reported that there had been no complaints of bullying or harassment over the time period for the Inquiry.

Although the development of this well constructed formal policy is welcomed, the Inquiry Committee were informed of a culture that made it difficult for staff to report concerns or implement changes in the delivery of care. This was reported by many nursing staff as an expectation that they would "toe the line" and by other disciplines as their having to be very careful about how they dealt with certain staff in case their access to patients was made more difficult.

There was a broad spectrum of staff and carers who expressed concern about this attitudinal culture and the suggestion that some members of staff used letters from their Union about other members of staff in a manner that led to personal distress.

### **Disciplinary Procedures and Complaints**

The document Trust in Care (2005) deals with disciplinary issues. Previously within Ireland personnel departments would undertake disciplinary procedures. The policy is now that human resource strategies ensure that managers receive training to deal with disciplinary matters and that H.R. offer a supportive role throughout the process. The Effective People Management course is the mainstay of training in this regard. Concern was expressed by Human Resources that there was a culture at the C.M.H. such that minor complaints were met with defensive attitudes by staff forcing more formal investigation of issues that could have readily been dealt with by less formal means. With regard to the more formal procedures Human Resources at the H.S.E. expected most issues to be dealt with at ward/hospital management level for nursing and care staff and informed the Inquiry Committee that ward managers implement investigation and if necessary disciplinary proceedings up to stage 3 i.e. Human Resources stated that local staff can issue verbal and written warnings. Human Resources stated that implementation of the new policy had been accompanied by training of key staff and believed that key members of the broad Management Team and Assistant Directors of Nursing at the C.M.H. had completed the Effective People Management training provided by the H.S.E. Human Resources felt that the knowledge base of management staff at the C.M.H. around these issues was good but that there had been a reluctance to engage with the approach as a whole. They acknowledged that the unions involved at the C.M.H. tended to involve Human Resources at the H.S.E. prematurely in the process rather than following through the local procedure and agreed that attention to such flawed procedures would be helpful. Human Resources staff stated that managers at each organisational base were encouraged to consult H.R. but that the current procedure is for the early levels of the disciplinary process to be firmly based within the C.M.H. The department agreed that the absence of any verbal or written warnings at the C.M.H. over the past year suggests that the new procedures have not become embedded as working practices. Human Resources informed the Inquiry Committee that they felt confident as a

department that they would take action on disciplinary matters if they were presented with appropriate investigation and evidence.

There was considerable discrepancy between the perception of management team members and that of Human Resources with regard to disciplinary proceedings. Management team members, A.D.O.N.s and superintendent care officers reported that they did not hold delegated responsibilities as managers in this area. It was reported that support offered by Human Resources in this area was not at the level of expertise required in an organisation of the complexity of the C.M.H. and was likened to basic I.R. advice rather than robust and creative partnership working.

#### **FINDINGS– HUMAN RESOURCES**

- 1. Recruitment appears to operate outwith an overall workforce strategy in relation to unit based staff underpinned by work by the H.S.E. The government ceiling on the recruitment of permanent staff and constraints on developing a more appropriate skill mix both have a serious impact on the ability of the C.M.H. to maintain appropriate levels of unit based staff in a cost effective manner. Centralised recruitment for the H.S.E. area does not take into account the specific needs of the C.M.H. In particular it does not emphasise the importance of forensic nursing experience and the interest of the applicants in furthering changes in practice.**
- 2. The D.O.N. and S.M.T. have worked with the H.S.E. to develop a ward management structure that will provide consistent leadership and support keyworking. This is in the process of being implemented.**
- 3. The senior nursing and care officer management group do not have a close working relationship with H.R. and consequently are not optimally supported in this area. Recent H.R. strategy of crucial importance to the C.M.H. has not become embedded as normal working practice at the hospital, particularly evident in the disparate understanding of disciplinary procedures.**

- 4. The Dignity at Work policy provides a supportive structure for protecting employees from bullying, harassment and sexual harassment. The C.M.H. has implemented this well constructed policy and this was welcomed by the Inquiry. There was however concern expressed to the Inquiry by a broad spectrum of staff about an attitudinal culture that made it difficult for staff to implement changes in practice or to report concerns without worry about possible unpleasantness from other staff.**
  
- 5. The C.M.H. does not have a staffside partnership committee that works with management on strategies that optimise patient care while valuing staff. It was reported that two of the unions, S.I.P.T.U. and the P.N.A have not met each other and that this is impeding the development of a joint committee. It was also evident to the Inquiry that some staff unions at the C.M.H. become involved in areas such as team working relationships and change management in a confrontational manner which inhibits appropriate resolution.**

#### **RECOMMENDATIONS-HUMAN RESOURCES**

- 1. Recruitment strategy should be reviewed by the H.S.E. giving particular consideration to targeted recruitment to best meet the overall aims of the service. This needs to be accompanied by joint work between the H.S.E., C.M.H. and relevant central government departments on skill mix and achievement of adequate staffing without regular use of overtime.**
  
- 2. It is essential for there to be a joint approach between the H.S.E. and C.M.H. on the full range of H.R. strategy and especially on disciplinary procedures alongside further development of less formal means of tackling unprofessional behaviour and grievances. We recommend that Human Resources and the S.M.T. review the current situation and formulate a plan for working closely together in a robust partnership. Given the onerous responsibilities of the D.O.N., A.D.O.N.s and Chief Superintendent care officer in this area a regular consultation forum may be appropriate.**

- 3. We recommend that the national bodies for the P.N.A. and S.I.P.T.U. prioritise work with their local representatives in developing a joint approach to consultation at the C.M.H and consider how best to support change management in the service.**



## **SECTION 12 - CLINICAL GOVERNANCE**

The designated person responsible for clinical governance is the Clinical Director who has extensive experience of managing forensic services. The Clinical Director does not have dedicated sessions for this work. The Clinical Director, Director of Nursing and General Manager, Heads of each clinical discipline and all consultants comprise the members of the Clinical Governance Committee. It is acknowledged that audit and governance structures within the Irish mental health system are at an early stage of development and in this context the Inquiry Committee considered the broad management team to be committed to implementing clinical governance to improve care despite limited resources to support this development.

### **Monitoring Quality of Care**

A range of methods are used to monitor care at the C.M.H. in addition to the regular clinical meetings (ward rounds and case conferences):

- Monthly visits to units to meet users by members of the senior management team. This was welcomed by users.
- Daily ‘walkabouts’ to all clinical areas by senior management.
- Quarterly attendance at the carer’s group by a member of the senior management team to elicit suggestions or complaints and to communicate regarding developments.
- A Policy Committee meets monthly and reviews all policies annually.
- A Clinical Risk Committee includes representatives of all disciplines, meets monthly and reviews all critical incidents. Action points are allocated and followed through by the meeting. A more detailed review of certain incidents through root cause analysis is in the process of being developed. The minutes of this meeting from April 2005 until August 2006 were reviewed by the

Inquiry Committee. More detail of this is given in Section 9 (Risk Management). Incident Report forms are also reviewed at the weekly meeting of the Senior Management Team. A Health and Safety Officer is employed for 19 hours per week.

- Complaints are reviewed by the Senior Management Team.
- A Clinical Audit Committee was established during 2005 and meets monthly. At the time of the visit it was in the process of developing audit topics and standards and a review of standards in psychopharmacology had been set up.
- A Programme Planning Committee co-ordinates treatment, rehabilitation and activity programmes.

The Assistant Directors of Nursing take responsibility for monitoring standards of care on the wards and the Senior Management Team report to the local Health Office Manager regarding care standards.

### **Clinical Effectiveness and Audit**

The Senior Management Team were concerned about the limited support from the Health Service Executive for resources to support audit and assist in the development of clinical governance notwithstanding the lack of specific resources.

A priority has been to establish a database of all admissions and discharges including demographic and clinical information that will inform practice. Proposed developments include securing defined financial support for audit, benchmarking with other services and the establishment of an advisory board of stakeholders that will involve users and carers. The service appointed two Psychology Assistants in February 2006 to carry out systematic measures of clinical outcomes including length of stay and a user satisfaction survey; the service is developing standardised measures of individual mental health needs combined with an assessment of therapeutic interventions during particular time intervals.

The service uses clear guidelines for managing and recording interventions but there is variability between professional groups with regard to their evaluation of adherence to guidance. The M.D.T.s work together to implement guidance from the literature and professional bodies e.g. formal risk assessment utilises well recognised instruments including the HCR20 which is repeated at regular intervals. Local guidelines based on prescribing protocols have been implemented by the medical staff in relation to the management of treatment resistant schizophrenia (from the American Psychiatric Association, the U.K. National Institute of Clinical Excellence and the Maudsley Hospital). The Occupational Therapy Department adhere to the 'Mission and Process' document developed by the team and informed by recognised international good practice. A similar approach appears embedded within Social Work and Clinical Psychology. A range of research projects including some of international standing have been completed by members of staff with a particularly high standard of work by the medical staff. In contrast there is no consistent and coherent model of nursing care apart from the model on Unit 4 where the team works together on individual therapeutic programmes to minimise maladaptive behaviour. Most of the audits being undertaken during the period of the Inquiry relating to nursing intervention i.e. of seclusion, nursing care plans, risk assessment and incident report forms have focussed on recording whether or not the relevant documentation has been completed. The quality of the documentation has not been examined and in relation to the audit of use of seclusion and care plans consideration of the content of the care plan could have usefully been included. An exception was the careful study of risk assessment scores in relation to unit based placement across the hospital.

The Clinical Director ensures that useful information on evidence based practice is made available electronically to all consultants and heads of discipline. Heads of discipline provide this information to their professional groups. The Inquiry Committee again considered there was disparity between the experience of professional groups with many nursing, care and some vocational staff presenting as being less knowledgeable of current guidance in mental health practice. This is recognised by the C.M.H. and a practice development co-ordinator was appointed in 2005 to assist with the development of evidence based nursing practice at ward level.

### **Service User and Carer Views**

Service user satisfaction surveys were carried out during 2001 and 2003 and this was due to be repeated in 2006. A carers' satisfaction survey was completed in 2003. A smoking preference survey for service users and staff led to the C.M.H. not using the derogation option in relation to anti-smoking legislation.

### **Information Management**

The current situation regarding information technology within the C.M.H. was an area where the broad management team would value resources such that this could support improvements in the quality of care.

There is no budget available for information management and technology. Support for PC's and lap tops comes from shared services at Dr. Stevens Hospital and the service is reported not to be user friendly although courses in basic computer skills are provided. Research databases and statistical advice are offered through the I.T. service at Trinity College Dublin. Senior Clinicians have skills in the area and those in post graduate training within the service have access to training in these areas including use of SPSS.

Weekly waiting lists and in-patient lists are stored electronically. An electronic database of all admissions and discharges is complete from the 1<sup>st</sup> January 1997 to 31<sup>st</sup> December 2005 and this is actively researched with regard to forensic psychiatric need. Audit/research material stored electronically is anonymised as far as possible. It was reported that clinicians in each MDT (excluding ward based staff) and administrative staff have access to PC but members of the MDTs stated that the PCs were shared within each team and access to a PC was often problematic. Ward based staff have limited access to PC. Sharing of information is carefully considered by clinical teams with reference to guidance from the Medical Council and in relation to child protection with reference to the document 'Children First'.

#### **FINDINGS-CLINICAL GOVERNANCE**

- 1. The broad management team are committed to implementing clinical governance aimed at monitoring and improving the quality of care despite limited resources to support this.**
- 2. The Clinical Director takes lead responsibility for Clinical Governance and while he prioritises the area he does not have time allocated to the task.**
- 3. There is wide disparity between professional groups in relation to their involvement in audit and clinical effectiveness initiatives with much less involvement of nursing and care officers.**
- 4. Given the range of responsibilities and expectations of modern governance structures information management and technology is inadequately resourced.**

#### **RECOMMENDATIONS-CLINICAL GOVERNANCE**

- 1. The Clinical Director requires dedicated time to fulfil his role in Clinical Governance.**
- 2. It is essential that all staff are aware of best practice in their area and that they adhere to guidelines in this respect. There should be a particular focus on training and support for nursing and care staff in implementing best practice and quality initiatives.**
- 3. Adequate resources should be made available for information technology that supports Clinical Governance.**

## CONCLUSION

The custodial emphasis noted in the Mental Health Commission's Annual Report of 2004 is clearly a complex matter and one that particularly impacts on the patient experience at the CMH and the predominant culture on the wards. This remains a concern and is unacceptable in any modern forensic mental health service. It has proved particularly difficult to secure changes in working practice at Unit level which have an immediate and personal impact on the experience of being a patient at the CMH and to ensure that Unit-based nursing and care staff are active participants in clinical governance initiatives.

Appropriate risk management is central to the provision of care in forensic mental health services. We consider however that a more individual approach to care can form part of safe working practices for patients at the CMH to ensure optimal quality of life and timely rehabilitation. We have drawn particular attention in the body of the report to current practice in the area of risk management, use of seclusion and the need to prioritise development of a more appropriate service for women. The lack of an appropriate range of forensic services for women is of concern. In broader terms the Inquiry considers that the absence of a coherent model of key working, the continuation of central rostering and the need for other members of the multi-disciplinary team to have strong working alliances at Unit level must be addressed. The support of the HSE, staff associations and other agencies with responsibility for mental health care and criminal justice is essential.

It is clear the Senior Management Team and heads of disciplines have secured a range of achievements over the last two years. These include the implementation of a training programme in the safe management of aggression, the opening of a specialist behavioural unit and a new admission unit. Workforce development in relation to ward management, continuing development of the service to prisons and closer working with users and carers have also occurred. The ending of slopping out and routine perusal of patients' mail were implemented during the year of the Inquiry. The broad management team at the CMH is commended for their work in securing this progress.

The Inquiry recommends that the Mental Health Commission uses the regular inspections of the hospital by the Mental Health Inspectorate to monitor progress in these areas. We would like to acknowledge the support of staff in working with the Inquiry.

## **Specific Recommendations/Overall Recommendations**

### **FINDINGS – WOMEN’S SERVICE**

- 1. The décor and finishing of the unit is not of a high standard and furnishings did not support a wide choice of daily activities.**
- 2. Only one of the small secure courtyards on Unit A is furnished for recreational use and regularly used by patients. The courtyard in regular use is pleasant and has further potential.**
- 3. The seclusion rooms do not have associated toilet facilities. One of the rooms has no natural light and is not of an acceptable standard for use.**
- 4. The environment provided for women does not include step down facilities.**
- 5. Women patients are not nursed according to their individually assessed needs and some patients are locked in their rooms when their risk can be satisfactorily managed in other ways.**
- 6. Keyworker arrangements on the ward are inadequate being based on a shift nurse pattern rather than promoting continuity of care over an extended period.**
- 7. A number of patients did not seem familiar with their care plan and said they had not received a copy.**
- 8. Seclusion appears to be used regularly with little use of alternatives to seclusion. Women’s underwear is routinely removed during seclusion and they are not allowed appropriate choice of sanitary protection.**
- 9. Policy on the unit allows male staff to be involved in the restraint of women patients. Involvement of male staff did not appear to be confined to exceptional situations.**



10. Women patients have good access to individual therapies that do not require specialised facilities. Wider rehabilitation including activities of daily living and creative use of leisure seems very limited. Women were not allowed to prepare their own drinks or meals or to regularly do their own laundry. Activities off the unit were restricted with an over emphasis on routine contract work for which there was little enthusiasm.
11. Child visiting is positively managed by Social Work and nursing members of the multidisciplinary team. Social Workers are actively engaged in family contact and support but there appeared to be variability in how far unit based staff were integrated in the approach in this important area.
12. In relation to physical healthcare needs women had access to the gym on a daily basis but limited availability of brisk walking or swimming. Access to appropriate health screening was not available at the time of the Inquiry.
13. All mealtimes are currently within one 8 hour period out of 24 hour period and it is unlikely this reflects patient preference.
14. Ward based staff work with staff from other disciplines (consultants, NCHD's, social work, occupational therapy and psychology) across all multi-disciplinary teams which may contribute to the difficulties in developing new ways of working with this challenging group of patients.

#### **RECOMMENDATIONS-WOMEN'S SERVICE**

1. The physical environment of the women's unit should be improved. Immediate attention should be given to refurbishment and the enhancement of both courtyard areas.
2. Seclusion facilities should be reviewed and the most unacceptable seclusion room taken out of use.
3. The Inquiry Committee supports the development of step-down rehabilitation facilities for women and commends the links being developed with local community facilities. In the short term there should be discussion

**within the staff and patient group of creative ways to facilitate rehabilitation as patient's progress.**

- 4. Women patients should have a care plan that reflects their individually assessed needs and should not be locked in their rooms regardless of their risk management.**
- 5. Continuity of staffing on the women's unit is essential to facilitate effective keyworking and to develop a ward culture sensitive to the needs of women.**
- 6. The use of seclusion on the unit should be reviewed and the practice of routinely removing women's clothes and underwear in seclusion should cease.**
- 7. Control and restraint on the women's service should be carried out by female members of staff save in exceptional circumstances. We recommend that additionally the policy should not allow removal of female patients' clothes by male members of staff. Training in gender aware approaches to control and restraint would be helpful.**
- 8. Patients should be fully conversant with their care plans and receive a copy of their care plan. This should include a rehabilitation plan with particular emphasis on the maintenance of skills of daily living.**
- 9. Consideration should be given to how best unit based staff can work with social work colleagues in providing an integrated approach to family contact.**
- 10. Access to appropriate screening in women's health should be facilitated. Such access should not be dependant on service development.**
- 11. There should be some choice available with regard to eating later in the day if this is preferred by individual patients.**
- 12. The Inquiry Committee considers that the provision of the women's service should be facilitated by a consultant led team that would best support the development of a cohesive culture and treatment programme. It is recommended that a unit based multi-disciplinary team for the women's**

service is developed with opportunities for professional links including visits and exchanges of staff with other forensic mental health services facing similar challenges of providing for patients with differing dependency and security needs.

## **Male Units**

### **FINDINGS-UNIT B**

- 1. Five beds are not in use due to staffing and environmental issues at the time of the visit**
- 2. The inquiry committee found that efforts had been made, even in the absence of continuity of staff, to introduce a keyworker system**
- 3. It appears from records that most patients admitted to Unit B are placed in seclusion independently of any risk assessment**
- 4. The secure outside area is too small and lacks a grass area and shelter**
- 5. The unit was not self staffing**
- 6. Five multidisciplinary teams have access to the beds on this unit**
- 7. All patients are locked in their bedrooms at night and there is no access to their rooms during the day**
- 8. There was no clinical supervision for the unit based staff**
- 9. Unit based staff reported that they were not involved in the planning of this unit. However the Senior Management Team informed the Inquiry Committee that there was a comprehensive consultation process.**
- 10. The physical environment needed some attention**
- 11. All patients were supervised in the bath independently of any risk assessment**

### **RECOMMENDATIONS-UNIT B**

- 1. Appropriate resources and environmental changes should be made to ensure the five beds not in use on the unit are commissioned.**

- 2. The use of seclusion must be in line with the rules on seclusion published by the Mental Health Commission on the 1<sup>st</sup> November 2006. Alternatives to seclusion must be examined and documented in the patients care plan.**
- 3. Access to bedrooms during the day should be determined primarily on an individual basis and should be determined by the risk posed by the individual patient.**
- 4. The secure facility outside the unit should be redeveloped to ensure that the needs of the patient are met and that the environment has appropriate and safe facilities.**
- 5. All essential maintenance work should be carried out and a regular maintenance programme in place.**
- 6. The need to supervise patients in the bath should be determined primarily on an individual basis and should be determined by the risk posed by the individual patient.**

#### **FINDINGS-UNIT 2**

- 1. The uniform locking of bedroom doors at night is unacceptable**
- 2. Although the practice of slopping out had ceased, patients now had to bang on their bedroom door to be taken to the toilet**
- 3. On the day of the visit the bedrooms were stuffy and had steel shutters on the windows, which were locked at night. There was no means of ventilating the rooms.**
- 4. Subsequently the inquiry committee have been informed that the shutters have been removed and replaced with macrolon Perspex, which is an improvement but still leaves the problem of inadequate ventilation**
- 5. Five multidisciplinary teams have access to the beds on this unit**

- 6. Unit based staff felt under represented in the multidisciplinary teams and undervalued at team meetings and case conferences.**
- 7. The venues for team meetings varied between the unit and the conference room**
- 8. There was no keyworker system in the unit and no model of care.**
- 9. Many patients had little knowledge of their care plan and some stated that they did not have a copy of their care plan**
- 10. The unit was not self staffing**
- 11. There was no choice allowed in whether the patients went outside for smoking breaks**
- 12. There was little access to the grounds for the patients. Quite often there were insufficient staff to escort the patients**
- 13. No patients are considered for unescorted parole in the grounds**
- 14. There was a time delay in moving patients from unit 2 to unit 3 for continued rehabilitation**
- 15. The cleanliness of the unit was not always satisfactory**
- 16. There was a lack of privacy in the toilets and bathrooms**
- 17. There was no clinical supervision for the unit based staff**
- 18. There was a lack of information available to staff on the unit from the management team on issues pertaining to audit and service development**

- 19. A number of patients complained about the over pricing in the shop outside the hospital that they had to use.**
  
- 20. The courtyard available to the patients lacked any stimulus and was not conducive to recreational use due to its dilapidated state and oppressive façade. It looks tired dated and custodial**

#### **RECOMMENDATIONS-UNIT 2**

- 1. The problem of ensuring that the bedrooms have appropriate ventilation must be addressed.**
  
- 2. Patients should be given a choice whether they go out to the courtyard for smoke breaks.**
  
- 3. There should be sufficient resources to ensure that patients have access to fresh air.**
  
- 4. The courtyard facility should be redeveloped to ensure that the needs of the patient are met and that the environment has appropriate and safe facilities.**
  
- 5. The facilities in the toilets and bathrooms should be of sufficient standard to maintain the patients dignity balanced with risk factors.**
  
- 6. There should be a clear system of communication between the Senior Management Team and the units' staff.**
  
- 7. The patients' issues with the use of the external shop should be addressed.**

**FINDINGS-UNIT 3**

- 1. The uniform locking of bedroom doors at night is unacceptable**
- 2. Although the practice of slopping out had ceased, patients now had to bang on their bedroom door to be taken to the toilet**
- 3. Unit based staff felt under represented in the multidisciplinary teams and undervalued at team meetings and case conferences.**
- 4. The venues for team meetings varied between the unit and the conference room**
- 5. There was no keyworker system in the unit and no model of care.**
- 6. The unit was not self staffing**
- 7. There was no choice allowed in whether the patients went outside for smoking breaks**
- 8. A number of patients felt that there was a threat of being moved to Unit B if they became unwell**
- 9. The courtyard available to the patients lacked any stimulus and was not conducive to recreational use due to its dilapidated state and oppressive façade. It looks tired dated and custodial**
- 10. The Perspex on the bedroom windows leaves the problem of inadequate ventilation**
- 11. Five multidisciplinary teams have access to the beds on this unit**
- 12. There was a shortage of individual therapies available**
- 13. Some patients were unaware of their rights**

14. All visits had to take place in the dining room
15. A number of patients complained that the food was cold
16. A number of patients complained about the prices in the outside shop.

### **RECOMMENDATIONS-UNIT 3**

1. The problem of ensuring that the bedrooms have appropriate ventilation must be addressed.
2. Patients should be given a choice whether they go out to the courtyard for smoke breaks.
3. The courtyard facility should be redeveloped to ensure that the needs of the patient are met and that the environment has appropriate and safe facilities.
4. The patients' issues with the use of the external shop should be addressed.
5. The issue patients have that there is a threat of a move to Unit B if they become unwell should be addressed and any moves to a higher level of security should be determined primarily on an individual basis and should be determined by the risk posed by the individual patient.
6. Patients should have access to more individual therapies on the unit.
7. A system must be in place to ensure that all patients are aware of their rights pertaining to their detention.
8. Patients' issues with the quality of food available should be addressed.



**FINDINGS-UNIT 4**

- 1. The aim of reducing the amount of seclusion appears to have been achieved. The inquiry committee however were unable to verify this as it has only received the records of seclusion up to November 2005 despite requesting more up to date information. From discussions with unit based staff and patients on the unit it appears that levels of disturbance had dropped dramatically**
  
- 2. The inquiry committee found that there is a high ratio of staff to patients which enables individual programmes to be carried out and facilitates the Behavioural Intervention Plan**
  
- 3. The inquiry committee found that there is one multidisciplinary team responsible for all patients in the unit. This facilitates individual programmes, management and functioning of the unit. It enables staff on the unit to feel that they are part of a team and allows one point of referral and team discussion.**
  
- 4. There was no keyworker system in the unit**
  
- 5. The unit was not self staffing**
  
- 6. There is a rehabilitation focus in the unit with the stated aim of moving patients to less restrictive environments when appropriate. However patients with physical disabilities are transferred to the unit solely because it is on the ground floor and has higher staff to patient ratios**
  
- 7. Each patient has an individual behaviour programme with input from unit staff and psychology. All staff are trained in RAID. It was obvious that all staff interviewed were very positive about the function of this unit**
  
- 8. Unit based staff were involved in the planning of this unit**

9. **The physical environment needed some attention**

#### **RECOMMENDATIONS-UNIT 4**

1. **All essential maintenance work should be carried out and a regular maintenance programme in place.**

#### **FINDINGS-UNIT 7**

1. **The uniform locking of bedroom doors at night is unacceptable**
2. **Although the practice of slopping out had ceased, patients now had to bang on their bedroom door to be taken to the toilet**
3. **Unit based staff felt under represented in the multidisciplinary teams and undervalued at team meetings and case conferences.**
4. **The venues for team meetings varied between the unit and the conference room**
5. **There was no keyworker system in the unit and no model of care.**
6. **The unit was not self staffing**
7. **There was little access to the grounds for the patients. Quite often there were insufficient staff to escort the patients**
8. **No patients are considered for unescorted parole in the grounds**
9. **Many patients had little knowledge of their care plan and some stated that they did not have a copy of their care plan**
10. **Some patients were unaware of their rights**

- 11. A number of patients felt that there was a threat of being moved to Unit B if they became unwell**
  
- 12. There was a lack of information available to staff on the unit from the management team on issues pertaining to audit and service development**
  
- 13. The physical environment needed some attention**
  
- 14. Five multidisciplinary teams have access to the beds on this unit**
  
- 15. All visits had to take place in the dining room**
  
- 16. A number of patients complained that the food was cold and insufficient amounts**

#### **RECOMMENDATIONS-UNIT 7**

- 1. The issue patients have that there is a threat of a move to Unit B if they become unwell should be addressed and any moves to a higher level of security should be determined primarily on an individual basis and should be determined by the risk posed by the individual patient.**
  
- 2. A system must be in place to ensure that all patients are aware of their rights pertaining to their detention.**
  
- 3. Patients' issues with the quality of food available should be addressed.**
  
- 4. There should be a clear system of communication between the Senior Management Team and the units' staff.**
  
- 5. All essential maintenance work should be carried out and a regular maintenance programme in place.**

6. **There should be sufficient staffing resources to ensure that the patients have their escorted parole in the grounds of the CMH.**

#### **FINDINGS-HOSTEL WARD**

1. **The inquiry committee found that there was a perception among patients that they would be transferred to restrictive units if they reported any deterioration in their mental health or made complaints. The patients thought that if someone returned to another unit then their place in the hostel would be lost although senior management stated that this was not necessarily the case. The inquiry committee was concerned that feeling unable to report symptoms or raise complaints meant that patients mental well being was at risk as well as the ability to build a relationship with their treating team and unit based staff**
2. **The inquiry committee found that the openness and homeliness of the Hostel Ward was conducive to rehabilitation. However the lack of use of the kitchen for patients causes concern.**
3. **The inquiry committee found that the inconsistency of staffing in the hostel ward was extreme and interfered with ongoing rehabilitation programmes**
4. **There was no keyworker system in the unit and no model of care.**
5. **The unit was not self staffing**
6. **The physical environment needed some attention**
7. **Five multidisciplinary teams have access to the beds on this unit**
8. **Many patients had little knowledge of their care plan and some stated that they did not have a copy of their care plan**

9. **Patients were being supervised when using the telephone**
  
10. **It was reported that all 10 patients in the hostel ward could move on to community placements**
  
11. **Some nursing staff reported that they were afraid to flag problems as it may effect their career prospects within the CMH**

#### **RECOMMENDATIONS-HOSTEL WARD**

1. **Alternative accommodation should be sourced in conjunction with the HSE for the patients in the Hostel Wards if they no longer require the facilities of a secure hospital.**
  
2. **The issue patients have that there is a threat of a move to Unit B if they become unwell should be addressed and any moves to a higher level of security should be determined primarily on an individual basis and should be determined by the risk posed by the individual patient.**
  
3. **Patients should not be supervised on the telephone.**
  
4. **All essential maintenance work should be carried out and a regular maintenance programme in place.**
  
5. **There should be a clear system of communication between the Senior Management Team and the units' staff.**

## OVERALL RECOMMENDATIONS FOR UNITS

The following recommendations arise from the findings from a number of units:

- 1. With the exception of Unit 4 all 5 multidisciplinary teams have access to beds in all units. Consideration should be given to replicate the approach to service delivery in Unit 4 which has a dedicated MDT providing care in which nursing staff feel involved.**
- 2. All units in the CMH should be self staffing to ensure continuity of care and to enhance the unit based staff' role and responsibilities within the MDT.**
- 3. With the development of multidisciplinary care plans a keyworker system should be introduced ensuring that each patient has a keyworker from the most appropriate profession.**
- 4. All patients should be involved in their care plan and should receive a copy.**
- 5. Apart from the Hostel Ward no patient has unescorted parole in the grounds of the CMH. A system should be introduced to give patients unescorted parole in the grounds determined primarily on an individual basis and determined by the risk posed by the individual patient.**
- 6. A consistent model of care should be implemented on all units.**
- 7. The venues for team meetings should be consistent amongst all teams ensuring that all disciplines can attend and contribute to the care process.**
- 8. The locking of bedrooms should be determined primarily on an individual basis and should be determined by the risk posed by the individual patient.**

- 9. Those patients who have their bedrooms locked should have call buttons in their rooms to be able to communicate with staff when they require assistance.**
  
- 10. Any contract with cleaning services should ensure that high standards of hygiene and cleanliness are met at all times.**
  
- 11. All staff should have access to clinical supervision.**

## **SECLUSION**

### **FINDINGS - SECLUSION**

- 1. Amount of Seclusion.** The evidence points to an excessive use of seclusion specifically within the two admission wards. This was supported by the seclusion records noting the number of episodes of seclusion and the total number of seclusion hours. This view was expressed by many staff and by patients and carers.
- 2. Seclusion upon Admission.** There was some evidence to support the view that it was a routine procedure for patients to be placed in seclusion upon admission.
- 3. Seclusion Documentation.** The documentation supporting the use of seclusion was variable with at times no clear rationale for the use of seclusion detailed.
- 4. Recording of Patients Mental State During Seclusion.** There was often no recording of the patient mental state during periods in seclusion.
- 5. Alternatives to Seclusion.** There appeared to be limited alternatives considered to seclusion although the recent introduction of the RAID training did seem to be viewed as a positive move and appeared to be reducing the use of seclusion in Unit 4.
- 6. Audit of Seclusion.** There were no specific reviews by the MDT's to examine either the efficacy of seclusion for individual patients or any evaluation of the appropriateness of seclusion. Although an audit of seclusion was carried out, this focused on whether the documentation had been filled in and the amount of seclusion.
- 7. Recording of Control and Restraint.** It appears that many incidents where control and restraint was used were not recorded, in the relevant case notes, nor the untoward incident form or on a Prevention and Management of Violence and Aggression form.
- 8. Control and Restraint.** From those records that were reviewed by the Inquiry Committee it appears that the use of control and restraint is undertaken in a manner that was in keeping with current established practice.



## **RECOMMENDATIONS- SECLUSION**

**Seclusion – There are new regulations proposed by the Mental Health Commission that will form the basis of instigating and recording seclusion. It is, therefore, inappropriate to make any recommendations relating to this area. We are making a number of recommendations in additions to these proposals. These are:**

- 1. Alternatives to Seclusion. We recommend that alternatives to seclusion are examined and that these are documented in the patients' care plans.**
- 2. Evaluation of alternatives to Seclusion. In addition, to the previous recommendation, we suggest that there are regular evaluations of the efficacy of these alternative approaches to seclusion.**
- 3. Clinical Governance Committee. We propose that a multidisciplinary clinical governance committee be established, which includes members of the ward staff team, meet on a three monthly basis to examine seclusion. The areas to be examined should include; the amount of seclusion used, the reasons for seclusion, the length of seclusion, alternatives to seclusion used, and an evaluation of the appropriateness of seclusion and the efficacy of any planned alternatives.**
- 4. Control and Restraint. Many situations where control and restraint is used are not recorded in the relevant documentation. All episodes where control and restraint is used must be recorded. The policies surrounding the documentation of Control and Restraint should be reinforced and regularly audited. The proposed clinical governance committee would be an appropriate meeting for this to be reviewed.**

**(Seclusion – As of the 1<sup>st</sup> of November 2006 there are new rules on Seclusion and Mechanical Means of Bodily Restraint issued by the Mental Health Commission that form the basis of instigating and recording seclusion).**

## **RISK MANAGEMENT**

### **FINDINGS- RISK MANAGEMENT**

- 1. Risk Management Plans.** The risk assessments carried out in the Central Mental Hospital were of a high standard and thoroughly assessed the risk factors related to individual patients.
- 2.** The inquiry committee found little evidence of these assessments being used to form specific risk management plans. The management of risk within the TCP and nursing care plans focused on medication and security (primarily seclusion) responses.
- 3. Risk Assessment and Individual care.** Following on from the comments in the previous section; there was limited evidence of individual care being based on the risk posed by the individual patient.
- 4.** There was general agreement from staff that many patients were subject to levels of security that were far higher than their level of assessed risk. This led to many patients being in wards that reduced their capacity for rehabilitation and by implication would result in longer stays in the service. It is acknowledged that risk cannot be examined wholly on an individual basis. However, the view of the inquiry was that a balance between individual and ward context should be sought.
- 5. Locking of room at nights.** All of the rooms in the Central Mental Hospital, apart for the patients in the hostel were locked by 9pm. There were few members of staff who supported the view that every patient in a ward (including Unit B) should be locked in their room at night. However, most staff were of the opinion that there was a need for some patients to have their rooms locked at night. The evidence collected showed that the locking of rooms was not based on any assessment of the individual risk posed by each patient but on general concerns about overall security.
- 6. Slopping Out.** The practice of slopping out ended during the period of the inquiry and this is to be commended.
- 7. Time taken to open bedroom doors at night.** There were numerous complaints from patients and carers about the time it took for staff to open rooms to allow patients to go to the toilet. These views were supported by comments from many staff members.

8. **Parole.** The evidence gathered showed that there were inconsistencies in the granting of leave (such as patients having unaccompanied leave outside the grounds but no parole inside the Hospital). There were also concerns raised by patients and carers, and acknowledged by a number of ward staff, that the granting of parole often took a long time. The policy again did not appear to be based on the individual risk posed by the patient.
9. **Escorted visits in the grounds.** Most patients had to be escorted to any location outside of their ward. On some wards such as Unit 2 and Unit 3 this would require all patients to go to the exercise yard at given times to allow those patients that smoked to have a cigarette. Due to security concerns, and the lack of ability to assess patient on an individual level, those patients who were non-smokers were required to go to the exercise yard irrespective of whether they wished to go or not.
10. **Escorts for Therapeutic Activities.** The ability of patients to go to therapeutic activities or outside visits was adversely effected by difficulties in providing escorts.
11. **Privacy.** Due to security concerns there was constant monitoring of patients private communications. Staff were required to open letters coming into or going from the Central Mental Hospital and also to sit near to patients when they were on the phone to be able to listen in on any telephone conversations. The former had been ruled as illegal following the Central Mental Hospital asking for a legal ruling on the practice. However, this had been opposed by one of the staff unions who had continued to undertake the practice. Once again, neither practice was based on an individual assessment of risk but on a blanket risk strategy applied to the whole ward or hospital.

#### **RECOMMENDATIONS-RISK MANAGEMENT**

1. **Individual Risk Assessments** - There is a need for the individual risk assessments to be used to develop clear individual risk management strategies for each patient.
2. **Individual risk management plans.** There is an acknowledgement that risk management strategies have to take into account the overall risk

posed within an environment. However, any risk management strategy that is influenced by the communal environment should be clearly detailed in a finalised individual risk strategy.

3. **Locking of Rooms.** The locking of rooms should be determined primarily on an individual basis and should be determined by the risk posed by the individual patient. It is acknowledged that at times the communal safety of the unit will need to be taken into consideration which may require some rooms to be locked. If this is the case, this should be clearly documented in the case notes.
4. We suggest that the rooms on units are unlocked on a progressive basis with this commencing on Unit 7. The outcomes of this development can then be evaluated prior to it being introduced on Unit 3 with any adjustments following the evaluation. We recommend that this gradated approach be used to allow all units as having unlocked bedrooms while again acknowledging that the communal safety of the unit will need to be taken into consideration and that some rooms may be locked. If this is the case, this should be clearly documented in the case notes.
5. The locking of the bedrooms of women in Unit A should be examined on an individual basis.
6. Those patients whose bedrooms are locked at night should have this formally reviewed at regular intervals of not more than every three months.
7. Those patients who have their bedrooms locked should have call buttons in their rooms to be able to communicate with staff that they require assistance. There should also be an agreement in place that all patients will get a response from staff within two minutes of requesting assistance (unless there are exceptional circumstances).
8. **Escorts.** Leave within and outside of the hospital grounds should be determined by the individual risk posed by the patient and based on their risk assessment.
9. **Ground leave.** Unescorted leave within the grounds should be allowed and based on the assessment of individual risk.
10. **Application for Unescorted ground visits.** There should be a clearly detailed procedure by which patients and staff are aware of how patients

can apply for parole. The results of this application and reasons (if the application is unsuccessful) should be relayed to the patient and recorded in the patient's case notes.

**11. Opening Mail.** Unless there is a clearly identified risk (which is noted in the patient's case notes) staff should not either open outgoing or incoming mail. If the risk assessment identifies that a patient requires their mail to be opened, this should be done by two members of staff in the presence of the patient.

**12. Telephone Privacy.** Unless there is a clearly identified risk (which is noted in the patient's case notes) staff should not listen in on telephone conversations.

## **PROFESSIONAL GROUPS**

### **MEDICAL**

#### **FINDINGS- MEDICAL**

- 1. The CMH benefits from a skilled and motivated consultant group who provide a range of clinical, teaching, research and governance responsibilities.**
- 2. Medical staff play a prominent role in assessment and treatment. Documentation is of a high quality and clinical supervision and professional development given a high priority.**
- 3. The Inquiry Committee was concerned that the manner in which consultants work on all units within the hospital meant that the leadership potential of the medical staff working closely with particular units was insufficiently utilised to promote best practice.**
- 4. The NCHD's had a limited understanding of alternatives to seclusion and the role of risk management in everyday working practice.**

#### **RECOMMENDATIONS-MEDICAL**

- 1. Consideration should be given as to how best the medical staff can be aligned with particular units in order to utilise their knowledge and skills in developing a multidisciplinary model of care.**
- 2. Training initiatives for NCHD's should include consideration of alternative strategies to seclusion and visits to other forensic psychiatry services.**

### **OCCUPATIONAL THERAPY**

#### **FINDINGS-OCCUPATIONAL THERAPY**

- 1. The Inquiry found that the Occupational Therapy Department provided a good service as part of the multidisciplinary team. Their input was limited by the lack of resources such as therapy rooms and training kitchens.**

2. **The interface between Occupational Therapy and Vocational Training is problematic and this was considered to have a considerable impact on care planning.**
3. **There is variability in how far ward based staff work jointly with Occupational Therapy and facilitate the therapeutic programme. The interface on the women's service was reported to work well but in certain areas staff do not readily facilitate the work and have been known to disrupt therapeutic sessions by reading the newspaper or texting on mobile telephones.**
4. **Ongoing supervision for staff was available but deserving of some attention as to prioritisation.**

#### **RECOMMENDATIONS-OCCUPATIONAL THERAPY**

1. **Adequate resources must be developed to enable the Occupational Therapy Department to carry out appropriate therapy. This should include therapy rooms, training space and equipment.**
2. **The Head of Occupational Therapy should be supported by other staff and middle management in developing a therapeutic programme that best meets the needs of patients. A common referral path and review process should form part of a coherent approach involving Occupational Therapy and Vocational Training.**
3. **Occupational Therapy must be facilitated in ward and vocational areas and recognised by all staff as an essential part of individual care plans.**
4. **A programme of supervision must be in place to ensure all grades of OTs receive appropriate levels of supervision and support. This should include attendance at Occupational Therapy forums outwith the C.M.H. and visits to other secure facilities.**

## **SOCIAL WORK**

### **FINDINGS-SOCIAL WORK**

- 1. The development of systems of collaborative working with local services has been a priority and a Service Level Agreement has been set up with Dublin Mental Health Hostels.**
- 2. The establishment of carers support and forums is to be commended.**
- 3. Liaison for children visiting and the provision of child friendly visiting facility has been established.**
- 4. There are positive examples of partnership working with a range of voluntary and statutory agencies**
- 5. There is lack of involvement of nursing staff in MDT functioning and TCP process.**
- 6. There are difficulties with aftercare planning and lack of co-ordination between services**
- 7. There are disparity in benefits for different patients**
- 8. There is positive emphasis on providing training**
- 9. There is concern regarding the poor physical environment**
- 10. There is lack of rehabilitation facilities for women**
- 11. There are reports of involvement of male staff in restraint of women**
- 12. There are concerns expressed about the general use of seclusion**

### **RECOMMENDATIONS-SOCIAL WORK**

- 1. Nursing staff must be more involved with the MDT process and the TCP. Self staffing on units would enhance the process.**
- 2. A working Group should be established with the HSE to examine future placement in the community and other health care provisions for patients**
- 3. Essential maintenance should be carried out on all units and a maintenance programme put in place.**
- 4. The provision of services should be reviewed in line with recommendations in Section 4 and 5.**
- 5. The use of seclusion in the CMH should be revisited and alternatives to seclusion explored.**



## **PSYCHOLOGY**

### **FINDINGS-PSYCHOLOGY SERVICE**

- 1. The recruitment of psychologists to all MDT's is positive.**
- 2. The psychology service is to be commended for introducing the RAID® training.**
- 3. The Psychologists concur that nurse and care officers are not involved sufficiently in the T.C.P. and case conferences and that the lack of a key worker is impeding proper care planning.**
- 4. There are insufficient therapy and interview rooms for psychology.**
- 5. In common with Occupational Therapists, Psychology sessions are interrupted by ward staff.**

### **RECOMMENDATIONS-PSYCHOLOGY SERVICE**

- 1. Adequate resources should be made available to the psychology department to enable it to carry out its functions**
- 2. Psychology must be facilitated in wards and recognised by all staff as an essential part of the individual care plans.**
- 3. Unit staff should be supported in being involved in co-presenting groups and facilitating staff programmes.**

## **NURSING AND CARE OFFICERS**

### **FINDINGS-NURSING AND CARE OFFICERS**

- 1. The Inquiry Committee found that, due to shift system of staffing the wards, there is little continuity of care. The Inquiry Committee notes that there are advanced plans to introduce a ward management system. This proposal has been agreed following a ruling at the Labour Relations Court.**
- 2. There is no key working system in the Central Mental Hospital. In addition, different wards that have introduced key working have used different models.**
- 3. There is a shortfall of nursing staff due to the employment ceiling. This results in the reliance on overtime to allow the wards to be adequately staffed.**
- 4. In most wards nursing care plans were not up to date and progress notes bore little relationship to care plans.**
- 5. Ward staff are not actively involved in therapeutic activities. It was reported that on occasions some ward staff encourage non co-operation in the therapeutic activities.**
- 6. Many ward staff do not view themselves as part of the MDT. Separate care plans, and lack of ongoing communication enhances this view.**
- 7. The ward staff on SABU are the most integrated in terms of working collaboratively with other members of the MDT. They are also the most positive about MDT working. It is also the only unit within the service that has a dedicated MDT for one ward.**
- 8. There is a lack of knowledge of educational opportunities for care officers with regards working in a primary care role on the ward.**
- 9. Staff development opportunities are good.**
- 10. There is a perceived poor communication of information filtering down from the Senior Management Team and from case conferences.**
- 11. The CPN group have a close working relationship with a dedicated MDT team and also receive regular clinical supervision**
- 12. There appears to be very little (or no) research nor practice development undertaken by ward staff**

13. There is no monitoring of ethnic minority ward staff nor any diversity training
14. The participation of service users in their care plan is haphazard

#### **RECOMMENDATIONS-NURSING AND CARE OFFICERS**

1. The process of central rostering procedure should be reviewed. A system whereby dedicated ward staff are allocated to individual wards, or specific areas such as admission, medium secure care or rehabilitation.
2. A keyworking system needs to be developed and introduced to all wards using the same model of care
3. The employment ceiling should be rescinded
4. Nursing care plans should be regularly updated with audits undertaken on a periodic basis to ensure this occurs
5. Ward staff should be encouraged to develop therapeutic roles within the ward and to participate in developing therapeutic activities/groups with professional colleagues
6. All ward staff should receive regular clinical supervision
7. The service should examine ways of ensuring that ward staff are more firmly integrated with MDT's. This could be through dedicated MDT's for each ward, or into specific clinical areas (admissions, medium secure care, and rehabilitation).
8. The nursing care plans and TCP's should be combined into one overall care plan.
9. Care officers should receive training and support in primary care working
10. The policy regarding the dissemination needs to be reviewed and replaced with a more effective procedure
11. It would be beneficial for the CPN group to have formal links with ward nurse managers to enhance professional development and support
12. The service should encourage ward staff to undertake research and practice development projects
13. There needs to be monitoring of ethnic minority staff and diversity training

14. Service users should be involved in the development of their care plans and this formally recorded. Where this does not take place, the reasons should be documented. This should be regularly audited.

### **CATERING MANAGER**

#### **FINDINGS-CATERING MANAGER**

1. The Inquiry Committee found that the absence of assessment kitchens for occupational therapy programmes limited rehabilitation.

#### **RECOMMENDATIONS-CATERING MANAGER**

1. The issue of providing ADL kitchens for basic occupational therapy and rehabilitation must be addressed.

### **THERAPEUTIC ACTIVITIES**

#### **FINDINGS-THERAPEUTIC ACTIVITIES**

1. There are a number of different off unit activities for patients
2. There are very few unit based activities for patients unable to leave their units
3. Attendance at therapeutic activities is sometimes hindered by staffing difficulties such as central rostering, shift system, and lack of keyworker.
4. There is no centre for full assessment of DLS.

#### **RECOMMENDATIONS –THERAPEUTIC ACTIVITIES**

1. There should be unit based activities for patients unable to leave the units, based on patients individual care plan
2. Patients should be able to attend therapeutic programmes, groups and activities whenever scheduled. This should be facilitated by unit staff and a key worker system
3. There should be a dedicated daily living skills area where assessment and therapy can take place

## **VOCATIONAL OFFICERS**

### **FINDINGS-VOCATIONAL**

- 1. The Inquiry Committee found that there are difficulties in women patients attending vocational activities.**
- 2. The Inquiry Committee found that patients sometimes did not attend vocational activities due to lack of adherence to a patients individual care plan.**
- 3. The Inquiry Committee found that there was an incentive to attend industrial therapy through money payments, rather than attending vocational activities.**

### **RECOMMENDATIONS-VOCATIONAL**

- 1. Women patients should have opportunity to attend vocational activities**
- 2. Patients care plans should be followed in respect of therapeutic activities. Reasons for not adhering to care plans should be recorded.**
- 3. The issue of payment exclusively for industrial therapy should be reviewed.**

## **USERS AND CARERS**

### **FINDINGS-USERS**

- 1. The inquiry was unable to ascertain when patient satisfaction had last been assessed by the service nor the results of this assessment.**
- 2. When undertaking the Forensic Satisfaction Scale, the users of the service indicated that they were generally satisfied with the service received.**
- 3. Only one unit (Unit A) recorded dissatisfaction with the service.**
- 4. Within the eight subscales examined by the satisfaction scale, the majority recorded levels above the midpoint score indicating satisfaction with the service.**
- 5. Three sub-scales scores were below the midpoint score and one (finance) recorded a score that was some way below the mid-point score.**

### **RECOMMENDATIONS-USERS**

- 1. The factors surrounding the dissatisfaction reported in Unit A needs to be examined by the service. This is discussed in more detail in Section 4 of the inquiry report.**
- 2. There is a need for an examination of the financial difficulties that patients face and the assistance given to patients that may be experiencing financial difficulty.**
- 3. A regular assessment of patient satisfaction should be undertaken. If possible this should be done on a yearly basis with areas of dissatisfaction identified and remedial action undertaken.**

## **FINDINGS – CARERS**

- 1. There were differing opinions from carers as to the quality of the service in the Central Mental Hospital ranging from those that viewed the service in a positive light to those that had negative opinions of the service.**
- 2. It is acknowledged that great strides have been made in developing contacts and working with carers during the period of the inquiry, especially from the social work team.**
- 3. There have been recent positive developments with regards to the development of carer services. Two carers groups are functioning well and Schizophrenia Ireland are supporting carer developments in the service.**
- 4. The service detailed a number of proposed developments concerning carers in its clinical governance questionnaire that carers would be members of a proposed advisory board for the service and to have a greater role in reviewing policies.**
- 5. There are still a number of strongly held views held by carers concerning the perceived restrictive nature of the service, its prison-like mentality, and its coercive nature. We did not find that these practices were current at the Hospital.**
- 6. The inquiry was of the opinion that the service did not effectively communicate with carers on a consistent basis. This lack of communication had allowed a number of carers to develop the view that the service was hostile to them and to the patients.**
- 7. A number of carers had no regular contact with any member of the service.**
- 8. Carers were sometimes not being given clear information about the progress of the patient especially during the initial admission phase.**
- 9. There were occasions where carers were not aware of who was part of the patients care team. This would lead to carers not being aware of whom to approach or talk to about the care and treatment of the patient. This was especially the case when visiting the patient or when phoning the ward.**

- 10. Carers sometimes felt intimidated by case conferences due to the large number of staff present (many of them who were unknown to the carers), uncertainty about their role within the case conference, and a sense that they were unable to participate in these discussions as decisions about care had already been made beforehand.**
- 11. There was a limited involvement in any pre-discharge planning for a number of carers. Some carers had spoken of not being aware when patients had been transferred back to prison, or had been discharged into the community.**
- 12. There were limitations in the number of carers that were able to visit a patient at any one time. In addition, the visiting time was only for a limited periods. The inquiry were aware that some carers had travelled long distances to visit the patients and the visiting policy meant that either some carers were unable to visit the patients or that the amount of visiting time had to be divided to allow all carers to visit in the allotted time.**
- 13. All visits were held in the visiting hall and not in the patients' wards (apart from those patients in the Hostel ward). This did not seem to be based on individual risk. It also resulted in limited contact between ward staff and carers.**
- 14. The response of the service to complaints made by carers was variable.**



## **RECOMMENDATIONS- CARERS**

- 1. The positive developments made in developing the two carers groups and the input of Schizophrenia Ireland are welcomed and would encourage these being continued and expanded.**
- 2. The inquiry supports the proposal noted in the clinical governance questionnaire that carers be invited to participate in the proposed advisory board for the service and have a greater role in reviewing policies.**
- 3. There should be a dedicated named member of the service who has ongoing contact with the nearest relative or carer of each patient admitted to the Central Mental Hospital throughout their stay at the Hospital. This member of staff should be part of the patient's care team.**
- 4. These dedicated staff members need to be clearly identified to the carer as part of the admission process.**
- 5. Carers should be regularly updated on the care and treatment that the patient is receiving (subject to the patient being agreeable to this).**
- 6. Carers should be informed of the names of those staff that are part of the patients care team.**
- 7. Members of the ward staff who are part of the care team should be identified to carers.**
- 8. The needs of the carer should be when attending a case conference. This should include:**
  - a) Ensuring that the majority of staff present at the conference are known to the carer**
  - b) That a named member of staff be assigned the role of "supporter" to the carer.**
  - c) Providing carers with an overview of the nature, role, and procedures of a case conference**
- 9. The number of carers/family members who can visit at any one time (and the specified visiting times) should be reviewed. Special consideration should be given to those carers who have travelled a long distance.**
- 10. Consideration should be given as to whether patients (particularly on Unit 3 and Unit 7) should also be allowed to have visits on the ward. This**

**consideration should be based on individual risk factors rather than a blanket rule.**

- 11. The service should ensure that carers are clearly involved in any pre-discharge planning unless there are exceptional circumstances which would make this unreasonable.**
- 12. Any formal complaints made by relatives should be acknowledged within a two week period of receiving the complaint. Responses to the complaint should be made within a three month period (unless in exceptional circumstances and this should be relayed to the carer). This should be audited.**

### **ORGANISATIONAL ISSUES**

#### **FINDINGS- ORGANISATIONAL ISSUES**

- 1. A range of achievements have been secured over the past two years including continuing development of the service to prisons, close working with users and carers and the opening of the new admission ward.**
- 2. The interface between the senior management team, the H.S.E. and central government departments does not appear to support coherent strategic decision making and appropriate communication of key issues. This has a significant impact on staff and patient care.**
- 3. The management workload for the senior management team is considerable and a significant proportion falls on the Clinical Director who has extensive clinical commitments. The recent appointment of a hospital manager will strengthen the management team.**

#### **RECOMMENDATIONS-ORGANISATIONAL ISSUES**

- 1. The H.S.E. should review the process of strategic decision making in relation to the C.M.H. and secure proper engagement of the senior management team and central government departments in working together on key issues.**

- 2. Following the appointment of the general manager the workload of other members of the senior management team should be re-organised bearing in mind the wide responsibilities of the Clinical Director.**

## **HUMAN RESOURCES**

### **FINDINGS– HUMAN RESOURCES**

- 1. Recruitment appears to operate outwith an overall workforce strategy in relation to unit based staff underpinned by work by the H.S.E. The government ceiling on the recruitment of permanent staff and constraints on developing a more appropriate skill mix both have a serious impact on the ability of the C.M.H. to maintain appropriate levels of unit based staff in a cost effective manner. Centralised recruitment for the H.S.E. area does not take into account the specific needs of the C.M.H. In particular it does not emphasise the importance of forensic nursing experience and the interest of the applicants in furthering changes in practice.**
  
- 2. The D.O.N. and S.M.T. have worked with the H.S.E. to develop a ward management structure that will provide consistent leadership and support keyworking. This is in the process of being implemented.**
  
- 3. The senior nursing and care officer management group do not have a close working relationship with H.R. and consequently are not optimally supported in this area. Recent H.R. strategy of crucial importance to the C.M.H. has not become embedded as normal working practice at the hospital, particularly evident in the disparate understanding of disciplinary procedures.**
  
- 4. The Dignity at Work policy provides a supportive structure for protecting employees from bullying, harassment and sexual harassment. The C.M.H. has implemented this well constructed policy and this was welcomed by the Inquiry. There was however concern expressed to the Inquiry by a broad spectrum of staff about an attitudinal culture that made it difficult for staff to implement changes in practice or to report concerns without worry about possible unpleasantness from other staff.**
  
- 5. The C.M.H. does not have a staffside partnership committee that works with management on strategies that optimise patient care while valuing**

staff. It was reported that two of the unions, S.I.P.T.U. and the P.N.A have not met each other and that this is impeding the development of a joint committee. It was also evident to the Inquiry that some staff unions at the C.M.H. become involved in areas such as team working relationships and change management in a confrontational manner which inhibits appropriate resolution.

#### **RECOMMENDATIONS-HUMAN RESOURCES**

- 1. Recruitment strategy should be reviewed by the H.S.E. giving particular consideration to targeted recruitment to best meet the overall aims of the service. This needs to be accompanied by joint work between the H.S.E., C.M.H. and relevant central government departments on skill mix and achievement of adequate staffing without regular use of overtime.**
- 2. It is essential for there to be a joint approach between the H.S.E. and C.M.H. on the full range of H.R. strategy and especially on disciplinary procedures alongside further development of less formal means of tackling unprofessional behaviour and grievances. We recommend that Human Resources and the S.M.T. review the current situation and formulate a plan for working closely together in a robust partnership. Given the onerous responsibilities of the D.O.N., A.D.O.N.s and Chief Superintendent care officer in this area a regular consultation forum may be appropriate.**
- 3. We recommend that the national bodies for the P.N.A. and S.I.P.T.U. prioritise work with their local representatives in developing a joint approach to consultation at the C.M.H and consider how best to support change management in the service.**

## **CLINICAL GOVERNANCE**

### **FINDINGS-CLINICAL GOVERNANCE**

- 1. The broad management team are committed to implementing clinical governance aimed at monitoring and improving the quality of care despite limited resources to support this.**
- 2. The Clinical Director takes lead responsibility for Clinical Governance and while he prioritises the area he does not have time allocated to the task.**
- 3. There is wide disparity between professional groups in relation to their involvement in audit and clinical effectiveness initiatives with much less involvement of nursing and care officers.**
- 4. Given the range of responsibilities and expectations of modern governance structures information management and technology is inadequately resourced.**

### **RECOMMENDATIONS-CLINICAL GOVERNANCE**

- 1. The Clinical Director requires dedicated time to fulfil his role in Clinical Governance.**
- 2. It is essential that all staff are aware of best practice in their area and that they adhere to guidelines in this respect. There should be a particular focus on training and support for nursing and care staff in implementing best practice and quality initiatives.**
- 3. Adequate resources should be made available for information technology that supports Clinical Governance.**

## SECTION 13 - APPENDICES

### APPENDIX 1

#### Staff Letter

#### **Re: Notification of all staff on an Inquiry into the Central Mental Hospital**

Dear

I wish to inform all staff in the Central Mental Hospital that the Mental Health Commission has appointed a committee to carry out an Inquiry in the Central Mental Hospital under the following terms of reference:

*“To review current care and treatment practices in the Central Mental Hospital and to report to the Mental Health Commission”.*

In establishing this Inquiry the concerns of the Mental Health Commission were informed by the Inspector of Mental Health Services 2004 report on the facility, and the perceived custodial emphasis within the Central Mental Hospital.

In relation to the time period for the review, the Mental Health Commission agreed that the review should cover the period commencing January 1<sup>st</sup> 2004 and onwards.

The members of the Inquiry Committee are:

1. Dr. Janet Parrott, Chair of Inquiry Committee, Clinical Director and Consultant Forensic Psychiatrist, Oxleas NHS Trust, London, England
2. Dr. Teresa Carey, Inspector of Mental Health Services, Mental Health Commission.
3. Dr. Susan Finnerty, Assistant Inspector of Mental Health Services, Mental Health Commission.

4. Dr. Doug MacInnes, Reader in Mental Health, Christ Church University, Canterbury, Kent, England.
5. Mr. Des McMorrow, Assistant Inspector of Mental Health Services, Mental Health Commission.
6. Ms. Colette Ryan, Administration Officer, providing administrative support to the Inquiry.

The Inquiry will be conducted under Section 55 Mental Health Act, 2001:

55(1) The Commission may, and shall if so requested by the Minister, cause the inspector or such other person as may be specified by the Commission, to inquire into:

- (a) the carrying on of any approved centre or other premises in the state where mental health services are provided
  - (b) the care and treatment provided to a specified patient or a specified voluntary patient by the Commission
  - (c) any other matter in respect of which an Inquiry is appropriate having regards to the provisions of this Act or any regulations or rules made thereunder or any other enactment.
- (2) Where a person carries out an Inquiry under this section, he or she shall, as soon as may be, prepare a report in writing of the results of the Inquiry and shall submit the report to the Commission.
- (3) A report under *subsection (2)* shall be absolutely privileged wherever and however published.

Yours sincerely,

Dr. Janet Parrott,  
Chairperson, Inquiry Committee



**APPENDIX 2 – Documents reviewed in the course of the Inquiry**

Central Mental Hospital, (2004) *Through Care Policy (Discussion document only)*

Central Mental Hospital, (2004) *Admission Policy*

Central Mental Hospital, (2004) *Discharge Policy*

Central Mental Hospital, (2003) *Patient Observation Policy*

Central Mental Hospital, (2005) *Visiting Policy*

Central Mental Hospital, *Policy after a sudden death or a death suspected as being due to suicide*

Central Mental Hospital, (2004), *Policy and Procedures for notification of serious and untoward incidents, deaths, resulting reviews and inquiries*

Central Mental Hospital, (2002) *Seclusion Policy*

Central Mental Hospital, (2003), *Policy on the use of handcuffs (3<sup>rd</sup> draft)*

Central Mental Hospital, (2005) *Clinical Risk Management Policy*

Central Mental Hospital, *Policy on time out at the Central Mental Hospital*

Central Mental Hospital, (2000), *Policy on searching of hospital in-patients*

Central Mental Hospital, *General Security Policy*

Central Mental Hospital, (1998) *Escape Policy*

Central Mental Hospital, (2003) *Patient Escort Policy (working draft)*

Central Mental Hospital, *Hostel Operational Policy*

Central Mental Hospital, *Medium Secure Unit, (MSU-Unit 2), Operational Policy*

Central Mental Hospital, *Women's Unit (Unit a) Operational Policy*

Central Mental Hospital, *Male Unit (Unit B) Operational Policy*

Central Mental Hospital, *Men's Open Rehabilitation Unit (MORU\_Unit 7), Operational Policy*

Central Mental Hospital, *Men's Medium Secure (MMSU-Unit 3), Operational Policy*

Central Mental Hospital, *Selective Adaptive Behaviour Unit (SABU Unit 4), Operational Policy*

Central Mental Hospital, *Policy on the rostering of nursing and care officer staff*

Central Mental Hospital, *Policy and Practices in relation to family, carer and user involvement*

Dignity at Work Policy for the health service (2004)

Corporate Learning and Development, Training Prospectus "005/2006)

Policies and Procedures, East Coast Area Health Board, 2004

Staff Health, Safety and Welfare Department, (2006) Training Programme, Health  
Service Executive

## APPENDIX 3

### **Forensic Satisfaction Scale**

This scale was developed following a collaborative project between forensic mental health professionals and service users in the U.K. It consists of sixty questions that are ranked on a five point likert scale with higher scores indicating greater levels of satisfaction. A mean mid point score over three would indicate satisfaction with the service while scores below the mid point would indicate dissatisfaction. The further away the score from the mid point indicates increasing levels of satisfaction or dissatisfaction. Apart from a total (summative) score the scale also records eight sub-themes to assess specific aspects of service satisfaction (staff interaction, rehabilitation, milieu, communication, finance, safety, gender and overall satisfaction). The scale was assessed as being a reliable and valid measure of service user satisfaction and to be clearly understood and able to be completed by service users with a basic understanding of English. The scale does not appear to favour any socio-demographic group yet has the ability to distinguish between different levels of satisfaction for service users in different clinical areas. It is currently in use in approximately twelve different locations within the United Kingdom.

Reference: MacInnes, D., Beer, D., Keeble, P., Rees, D., Reid, L.  
Development of the forensic satisfaction scale. Report to  
the National Forensic Mental Health Research and  
Development Programme: pub. Liverpool 2006

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**FORENSIC SATISFACTION SCALE**

Table 3.1

Name of Ward	FSS Total Score (sd)	One sample t-test	P Value
Ward A	2.71 (0.42)		
Ward B	3.55 (0.16)		
Unit 2	3.16 (0.53)		
Unit 3	3.29 (0.35)		
Unit 4	3.09 (0.38)		
Unit 7	3.52 (0.39)		
Hostel	3.31 (0.71)		
Overall Score	3.23 (0.49)		

During the course of the inquiry thirty-nine patients at the Central Mental Hospital completed the Forensic Satisfaction Scale and the results are presented in Tables 3.1 and 3.2. This number reflects 51.32% of the patients within the Hospital. It is acknowledged that the non-respondents may have different opinions about the service. It is difficult to be absolute as to whether these non-respondents have considerably different opinions about the service than those who responded but we can state that the percentage of respondents was similar in all of the different clinical areas and at the very least the results can be viewed as giving a general overview of the perceptions of the service by the patients.

The overall score for the CMH was 3.23 and was statistically significant when analysed using a one sample t-test against a mid point score of three. This suggests that the patients tended to be satisfied with the service. Similar surveys in three medium secure units in the UK produced when examining the individual ward scores, some. All of the wards surveyed, apart from Unit A, scored above the mid point score suggesting that in these wards the patients were satisfied. In Unit A (the women's service) a score of 2.71 was recorded suggesting some dissatisfaction with the service provided. All of the sub scale scores were below the mid point score apart from safety and rehabilitation suggesting that the women felt safe on the unit and were that they were accessing therapeutic and social activities that they perceived as helpful for

when they would be discharged. However, concerns about communication and information sharing, finance, being treated different to the male patients, the unit environment and interaction with staff were all viewed negatively.

Table 3.2

Sub Scale Score	FSS Total Score (sd)	One sample t-test	P Value
Communication	2.91 (0.65)	- 0.92	0.37
Finance	2.75 (0.86)	-1.74	0.09
Gender	3.02 (0.87)	0.71	0.87
Milieu	2.95 (0.63)	-0.43	0.67
Overall	3.23 (1.21)	1.20	0.24
Rehabilitation	3.39 (0.55)	4.41	0.00
Safety	4.10 (0.55)	12.41	0.00
Staff Interaction	3.40 (0.65)	3.89	0.00
Overall Score	3.23 (0.49)	2.93	0.01

Table 3.2. records the subscale scores for the hospital, as well as the on sample t-test relative to the mid point score. It shows that five of the sub scale scores are above the mid point score and three are below. The three subscales below the mid point (thereby expressing some dissatisfaction with that part of the service) are communication, finance and gender. However, none of these scores is statistically significant although there is a tendency towards significance in the finance score suggesting that there is some level of concern about the lack of support surrounding financial support. In relation to the five sub scales (overall care, milieu, rehabilitation, safety and staff interaction) these suggest a mainly positive view of these aspects of the service and in the case of rehabilitation, safety and staff interaction issues, these were all viewed as statistically significant. The overall score of 4.10 for the sub scale of safety suggests that the patients were are highly satisfied with the lack of personal threat to their person within the service.

## APPENDIX 4 – References

### Legislation

Mental Health Act, 2001

Mental Treatment Act, 1945

Criminal Law (Insanity) Act, 2006

Department of Health and Children (2006) *A Vision for Change - Report of the Expert Group on Mental Health Policy*; Stationary Office, Dublin.

Department of Health and Children, (1998), *Guidelines in Good Practice and Quality Assurance in Mental Health*

Mental Health Commission (2004) *Mental Health Commission Annual Report 2004 - Including the Report of the Inspector on Mental Health Services; Mental Health Commission*

Mental Health Commission (2005) *Mental Health Commission Annual Report 2005 - Including the Report of the Inspector on Mental Health Services; Mental Health Commission*

Health Service Executive, (2005) *Trust in Care, Policy for Health Service Employers on Upholding the Dignity and Welfare of Patient/Clients and the Procedure for Managing Allegations of Abuse against Staff Members*

The Health Boards Executive, (2004), *Establishing and Conducting Committees of Inquiry, Practical Manual*

UK Healthcare Commission, (2005) *Inspection Manual Independent Health Care V2.0*

Health Care Commission, U.K. Clinical Governance questionnaire and Health Care standards.

Commission for Health Improvement, (2003) *Clinical Governance Review West London Mental Health NHS Trust*

Health and Social Care Advisory Service, London (2004) *Review of the Bracton Centre, Medium Secure Unit, Final Report, April 2004*

D. Beer, P. Keeble, D. MacInnes, D. Rees, L. Reid, Development of a Questionnaire to Measure Service User Satisfaction Within In-Patient Forensic Services - the Forensic Satisfaction Scale.

Adrian J.B. James, Tim Kendall and Adrian Worrall (ed) (2005), *Clinical governance in mental health and learning disability services*, Gaskell London

Policy for Health Service Employees on Upholding the Dignity and Welfare of Patients and the Procedure for Managing Allegations of Abuse Against Staff Members.

Policies and Procedures, East Coast Area Health Board 2003.

The Rules Governing the Use of Seclusion and Mechanical means of Bodily Restraint draft 3.1 June 2006. Mental Health Commission (for consultation).

**GLOSSARY**

<b>word/phrase</b>	<b>Definition</b>
admission	Admission is the entry of an individual to an approved centre;
advocate	A representative and supporter, who is chosen by the patient to represent his or her concerns and interests; may be formal or informal
clinical director	means a consultant psychiatrist appointed in writing by the governing body of each Approved Centre to be the clinical director of the centre under Section 71 of the Mental Health Act 2001;
clinical file	A record of the patient's referral, assessment, care and treatment while in receipt of mental health services;
clinical governance	A system for ensuring the standard of clinical practice including, clinical audit, education and training, research and development, risk management, clinical effectiveness and openness;
clinical psychologist	A psychologist with an accredited post-graduate professional qualification in clinical psychology;
Commission	means the Mental Health Commission established under section 32 of the Mental Health Act 2001;
CMH	The Central Mental Hospital is the National Forensic Service;
constant observation	Uninterrupted observation of an inpatient by a staff member;
consultant psychiatrist	A consultant psychiatrist who is employed by the HSE or by an approved centre or a person whose name is entered on the division of psychiatry or the division of child and adolescent psychiatry of the Register of Medical Specialists maintained by the Specialists maintained by the Medical Council in Ireland; (Section (2) Mental Health Act, 2001)
continuity of care	Integration and linkage of components of individualised treatment and care across health service agencies, according to individual needs;



control and restraint	“Restraint” may take many forms. It may be both verbal and physical and may vary in degree from an instruction to seclusion. The purposes of restraint are: to take immediate control of a dangerous situation; to contain or limit the patient’s freedom for no longer than is necessary; and to end or reduce significantly the danger to the patient or to others. (Code of Practice: Mental Health Act (1983) Definition (Section 19.6) <sup>2</sup>
corporate governance	The way in which a mental health service is directed and controlled so as to achieve its organisational goals and to deliver accountability, transparency and probity;
day centre	A facility that provides social care and support to service users. It may also offer elements of rehabilitation and treatment;
de-escalation	Process by which a potentially aggressive episode is managed by non-physical means;
de-escalation techniques	A series of techniques deployed to minimise the potential for situations to become unsafe which focus on empathy, language and bodily awareness;
dignity	The right of individuals to be treated with respect as a person in their own right;
discharge	Discharge is when a service user leaves an approved centre. In this context, it is a transfer in the location of the delivery of care from an approved centre to continuing support in the community, by primary care or community mental health services; or to an alternative care setting such as a nursing home or community residence; or possibly to a medical facility;
discharge plan	An information exchange tool and management plan, including management of risk. A contract between stakeholders that defines expectations, roles and responsibilities;
HCR-20 (Webster, Douglas, Eaves, & Hart, 1997a)	HCR-20 is a broad-band violence risk assessment instrument with potential applicability to a variety of settings. The conceptual scheme of the HCR-20 aligns risk markers into past, present, and future. Its 10 historical factors obviously

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	<p>concern the past. However, the HCR-20 contains 5 Clinical items that are meant to reflect current, dynamic (changeable) correlates of violence. The future is recognised in the 5 Risk Management items, which focus attention on situational post-assessment factors that may aggravate or mitigate risk. The HCR-20 takes its name from these three scales- Historical, Clinical, Risk Management.</p>
Health Service Executive	<p>means the body which has replaced the health boards and the Eastern Regional Health Authority as the overall national body for delivery of health services pursuant to the Health Act 2004;</p>
integrated care plan/care plan	<p>A documented set of goals collaboratively developed by the plan service user and the multi-disciplinary team. The care plan sets the direction for treatment and support, identifies necessary resources and specifies outcomes for the service user. The care plan is recorded in the one set of documentation;</p>
integrated care pathway	<p>An integrated care pathway is a multidisciplinary outline of pathway anticipated care, placed in an appropriate timeframe, to help a service user with a specific condition or set of symptoms move progressively through a clinical experience to positive outcomes;</p>
Inspector of Mental Health Services	<p>means a consultant psychiatrist appointed by the Commission holding the office of the Inspector of Mental Health Services in accordance with Section 50 of the Mental Health Act 2001;</p>
mental disorder	<p>3.- (1) In this Act [Mental Health Act 2001] “mental disorder” means mental illness, severe dementia or significant intellectual disability where- a) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, or (b) (i) because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to</p>

	<p>admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, and (ii) the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent. (2) In subsection (1)—</p> <p>“mental illness” means a state of mind of a person which affects the person’s thinking, perceiving, emotion or judgment and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment in his or her own interest or in the interest of other persons; “severe dementia” means a deterioration of the brain of a person which significantly impairs the intellectual function of the person thereby affecting thought, comprehension and memory and which includes severe psychiatric or behavioural symptoms such as physical aggression; “significant intellectual disability” means a state of arrested or incomplete development of mind of a person which includes significant impairment of intelligence and social functioning and abnormally aggressive or seriously irresponsible conduct on the part of the person;</p>
Minister	<p>means the Minister for Health and Children;</p>
mdt care plans	<p>Multidisciplinary care planning is a system of delivering patient care ensuring that the primary tenet is collaboration among disciplines. Multidisciplinary care planning enhances communication among disciplines and coordinates patient care services. A care plan is a written document that describes a care process for each patient within a service. It should reflect locally agreed guidelines, be evidence based and patient centred. It should include identified problems, plans and goals to achieve</p>

	targets as well as individuals with named responsibility and regular reviews. The care plan is developed with the patient and a copy given to the patient;
multi-disciplinary care planning	System of delivering care ensuring that the primary tenet is collaboration among all disciplines. Multi-disciplinary care planning enhances communication among disciplines and co-ordinates service user care services;
mdt key worker	A key worker is the prime therapist for each patient and can come from any discipline. He/she is actively involved clinically with the individual. The key worker role will vary locally but will include the following: Delivering and managing the care programme ensuring that all aspects of the assessment have been completed and the appropriate goals and actions have been identified and carried out. Coordinating the input and involvement of other workers and agencies. Ensuring that the care plans record is up to date and reflects the decisions taken at the MDT meetings. Working with the service user and ensuring that the care plan is current and reflects the users needs;
multidisciplinary team (mdt)	A mental health team comprising a variety of professional staff. Core team members are: psychiatrists, nurses, clinical psychologists, social workers and occupational therapists. Other special therapists may also be available;
multi disciplinary team (mdt) working	MDT teams function best as discreet specialised teams comprising health and social care staff under single management, which have: Staff members whose sole or main responsibility is working within that team; An adequate skill mix within the team to provide interventions; Strong links with other mental health services and a good knowledge of local resources and clear and explicit responsibility for local population and links to specified primary care services;
nursing model	A standardised model of nursing care, usually comprising of an assessment of needs, an intervention plan and regular

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	review of interventions;
referral	A request from one provider or organisation to another to provide care/service; or direction to the service user or on behalf of the service user to obtain additional care/services from another organisation or provider;
risk assessment	The process of risk identification, risk analysis and risk evaluation;
risk management	the culture, processes and structures that are directed towards realising potential opportunities while also managing adverse effects;
seclusion	The placing or leaving a person in any room alone, at any time, day or night, with the exit door locked or fastened or held in such a way as to prevent the person from leaving (Section 69 (2) Mental Health Act, 2001 Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint)
seclusion	Seclusion of a patient means the placing of a patient (except during the hours fixed generally for patients to retire for sleep) in any room alone and with the door of exit locked or fastened or held in such a way as to prevent egress of the patient (S.I. No. 261 of 1961);
team working	the members of a multidisciplinary team working together and sharing expertise in order to deliver a holistic mental health service.

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