REPORT OF THE COMMITTEE OF INQUIRY TO REVIEW CARE AND TREATMENT PRACTICES IN ST. MICHAEL'S UNIT, SOUTH TIPPERARY GENERAL HOSPITAL, CLONMEL AND ST. LUKE'S HOSPITAL, CLONMEL, INCLUDING THE QUALITY AND PLANNING OF CARE AND THE USE OF RESTRAINT AND SECLUSION AND TO REPORT TO THE MENTAL HEALTH COMMISSION.

2009

Mental Health Commission Statement on *Mental Health Act 2001, Section 55 Inquiry Report (To Review Care and Treatment Practices in St. Michael's Unit, South Tipperary General Hospital, Clonmel and St. Luke's Hospital, Clonmel including the Quality and Planning of Care and Use of Restraint and Seclusion).*

The Mental Health Commission, an independent statutory body, was established in April 2002, pursuant to provisions of the Mental Health Act 2001 (2001 Act).

Section 55 of the 2001 Act provides for the establishment of an Inquiry by the Commission into "the carrying on of any approved centre or other premises in the State where mental health services are provided".

In June, 2007, the Mental Health Commission decided to establish an Inquiry, as per Section 55 to "*To review care and treatment practices in St. Michael's Unit, South Tipperary General Hospital, Clonmel and St. Luke's Hospital, Clonmel, including the quality and planning of care and the use of restraint and seclusion and to report to the Mental Health Commission"*.

The members of the Inquiry Team established by the Mental Health Commission were:-

- Dr. Adrian Lodge, Mental Welfare Commission Scotland – appointed as Assistant Inspector Mental Health Services for the duration of the Inquiry;
- Mr. Jamie Malcolm, Mental Welfare Commission Scotland – appointed as Assistant Inspector Mental Health Services for the duration of the Inquiry;
- Mr. Des McMorrow, Assistant Inspector of Mental Health Services, Mental Health Commission;
- Ms. Maeve Kenny, Assistant Inspector of Mental Health Services, Mental Health Commission.

The Report of the Inquiry Team was considered by the Mental Health Commission at its meetings held on 29th January, 2009 and 24th February, 2009. The Commission made a decision to publish the Report.

The Commission works with all interested parties in relation to the promotion and fostering of quality mental health services. In that regard the Mental Health Commission has been informed of developmental plans announced by Professor Brendan Drumm for the mental health services in South Tipperary. The Mental Health Commission requires that a project plan for the development of the mental health services in South Tipperary be submitted by the Health Service Executive which will be time-bound and which shall have clear lines of responsibility for the implementation of the project plan. The Inspectorate of Mental Health Services will monitor closely the HSE project plan and report to the Mental Health Commission on a regular basis.

Signed: 

Dr. Edmond O'Dea
Chairman
Mental Health Commission

Date: 31st March 2009

REPORT OF THE COMMITTEE OF INQUIRY TO REVIEW CARE AND TREATMENT PRACTICES IN ST. MICHAEL'S UNIT, SOUTH TIPPERARY GENERAL HOSPITAL, CLONMEL AND ST. LUKE'S HOSPITAL, CLONMEL INCLUDING THE QUALITY AND PLANNING OF CARE AND USE OF RESTRAINT AND SECLUSION

2009

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Summary

Section 1: Introduction

In June 2007 the Mental Health Commission set up an inquiry under Section 55 of the Mental Health Act 2001. The remit of the inquiry was, *"To review care and treatment practices in St. Michael's Unit, South Tipperary General Hospital, Clonmel and St. Luke's Hospital, Clonmel, including the quality and planning of care and the use of restraint and seclusion and to report to the Mental Health Commission".*

Concerns about the services had been identified in several annual reports of the Inspector of Mental Health Services.

Section 2: Method and Process of the Inquiry

The inquiry team made two five-day visits to the hospitals in Clonmel, in August and October 2007. The team met on 15 other occasions but much of the work was completed outwith these meetings.

At the first visit to Clonmel the team met senior managers and representatives of professional organisations and trade unions and visited hospital wards, meeting staff and residents there. Meetings with individuals and staff groups were held during the second visit and community facilities were visited.

The descriptive sections of the draft report were circulated to the Local Health Manager and to staff organisations for correction and comment early in 2008 and a full draft report was circulated subsequently. The inquiry team was obliged to carry out further interviews in August and September as a result of comments received. Following further consultation with HSE South the report was submitted to the Commission in January 2009.

Section 3 of this report identifies the legal requirements and good practice standards against which the services were measured. **Sections 4 to 13** describe services in South Tipperary at the time of the inquiry team visits, unless otherwise stated. The views of residents are summarised in **Section 14**. **Sections 15 to 24** address the remit of the inquiry. **Section 23** covers notification of the admission of children, which was generally satisfactory. Some conclusions are drawn in **Section 26**.

Section 4: Current Service Provision

St. Luke's Hospital (134 beds) and St. Michael's Unit (49 beds) provided inpatient services for South Tipperary (pop. 83,221) and North Tipperary (pop. 66,023). Separation of the inpatient services, now in different HSE areas, had long been agreed in principle but no practical steps had been taken to achieve this. Long stay bed numbers had reduced over the years but the service relied heavily on inpatient care, having more beds for its population than anywhere else in Ireland in 2006. Two long stay wards remained in the original 1835 St. Luke's Hospital building; the other five wards and St. Michael's Unit, the admission unit, were sited in the hospital grounds, which were shared with South Tipperary General Hospital.

Community services were provided by three sector teams. The East and West Clonmel teams shared very cramped accommodation in Clonmel. The sector teams lacked key staff members; there were no occupational therapists. Clinical psychologists and community nurses were in short supply. Staff shortage affected the psychiatry of later life and child and adolescent psychiatry teams and there was no intellectual disability team. A rehabilitation team had recently been formed.

Section 15: Admission and Discharge

Admission to St. Michael's Unit was through one of seven clinical teams; two of these covered North Tipperary. There was a lack of offices and meeting rooms. Most admissions took place out of hours, preventing any serious consideration of alternatives. In reality there were few alternatives and, as admissions to long stay wards had almost ceased, the unit was almost always full.

Section 16: Care planning

Individual care plans, which must specify care and treatment, should be agreed between individuals and the multidisciplinary team. Plans must be reviewed regularly and recorded in a composite set of casenotes.

Residents of St. Michael's Unit attended the weekly meeting of their multidisciplinary teams. There were no comprehensive needs assessments or multidisciplinary care plans. Residents might have several clinical files, rather than a composite record. The relationships between needs, interventions and goals, recorded in nursing care plans, were often unclear.

No health or social care professional staff attended the weekly clinical meetings in St. Luke's Hospital and there were no multidisciplinary or composite records. The clinical records of most long stay residents contained little personal information, which is essential for needs assessments and person centred care. Psychiatric reviews and nursing care plan reviews were not based on comprehensive needs assessments and were carried out at variable intervals. The rehabilitation team was developing a multidisciplinary team approach.

Section 17: Therapeutic and recreational activities

Residents must have access to therapeutic services and programmes, as specified in individual care plans. Recreational activities should be available.

In St. Michael's Unit nurses coordinated a programme of activities but it was not individualised or needs based. Some sessions were run by external agencies but there was no occupational therapist. Several residents complained that there was very little to do. Little opportunity to exercise was a concern for many.

In the long stay wards in St. Luke's Hospital treatment options were limited by the lack of health and social care professional staff. Nursing staff organised some activities, when staffing permitted, and several residents attended the hospital occupational department. Activities were not needs based nor aimed at facilitating discharge, although the rehabilitation team was introducing this approach. Many residents were unoccupied for much of the time.

Section 18: Seclusion, restraint and observation

Seclusion is a safety measure, not a treatment, and should only be used as a last resort, when there is an immediate threat to the individual or others.

Seclusion was not always used as a last resort. Poor ward design, low staffing levels and a lack of activities to occupy residents contributed to more frequent use. An audit of the need for seclusion would assist in substantially reducing its use. A note of the consideration of alternative management, the finishing time of seclusion and the name of the member of staff were often missing from seclusion records. The use of physical restraint generally complied with legal requirements.

Most of the residents of St. Michael's Unit were required to wear nightclothes during the day. This appeared to be invariably linked to a raised observation level and was unnecessary

restrictive. Most long stay wards were locked and some staff referred to 'parole' for residents, although few were detained. No policy governed the locking of wards and the necessity was not reviewed. Residents' choices, freedoms and opportunities were restricted more than was necessary for their care and treatment and, as a result, their lives were impoverished. Risk avoidance often appeared to determine care approaches, rather than individual risk assessment.

Section 19: Staffing

Consultant psychiatrists had limited time for long-stay ward responsibilities because of sector commitments. Agreed nurse staffing levels were often not achieved because of unexpected absences and a 20% shortage of trained nurses. This led to extensive overtime working and inter-ward staff transfers. Residents' care was disrupted by the cancellation of activities and the absence of familiar staff. Unnecessary involvement of nurses in domestic tasks, such as serving meals and helping with laundry added to the effect of staff shortage. Managers and trade unions had disagreed over changes to skill mix.

There was no formal structure for clinical governance. Workforce planning and staff training were not based on an assessment of residents' needs. Training, clinical supervision and study leave were available to medical and health and social care professional staff. Clinical supervision was not systematically provided to nursing staff. It was not clear that nurses had received appropriate training because no training needs assessment had been completed. Some nurses who had trained in treatment techniques, such as behaviour therapy and psychosocial intervention, were unable to apply these in their work setting.

Section 20: Hospital Environment

The decor in St. Michael's Unit was monotonous and some areas needed redecoration. Quiet areas and activity rooms were insufficient and visits often took place at the bedside. The high observation dormitories were unsuitable for the care of severely ill residents during the day. Some showers required repair and appeared unsafe but maintenance and repairs were often significantly delayed.

St. Luke's Hospital appeared bare and monotonous. It was unsuitable as a home or for the provision of person centred care but one refurbished ward showed that the environment could be greatly improved. Most dormitories were bleak, with few personal items visible and little personal space. One dormitory lacked curtains. There were insufficient baths and showers. The areas outside wards were neglected. Defective flooring was evidence of delays in maintenance.

Vulnerable residents were put at risk by observation difficulties, caused by poor ward design and by sharing accommodation with others with challenging behaviour.

Clinical staff believed that funding was not available and made few requests for improvements. Senior managers said that this was not the case but accepted that maintenance was sometimes delayed.

Section 21: Intellectual disability service

One third of long stay residents had a diagnosis of intellectual disability. There was no specialist team and ward staff, although experienced, did not have specialist qualifications. In some wards long term benzodiazepine prescribing appeared to be associated with a lack of needs-based therapeutic and recreational activities.

At the end of 2007 a ward was designated for the care of most of the residents with intellectual disability and a group was set up to plan their discharge. An externally based clinical psychologist had begun assessments to facilitate this process.

Section 22: Risk management and injuries to residents

In September 2004 clinical risk managers reported on recent fractures suffered by residents, almost all unseen by staff. The pattern of injuries appeared to be unusual and the incidence was reported as being among the highest in local psychiatric hospitals. Non-accidental injury and a lack of adequate care were not mentioned in the report but were underlying concerns. Recommendations were made, aimed at identifying any underlying cause and at improving the care and safety of residents.

Managers and clinical staff did not meet until July 2005 to discuss the report. A specialist orthopaedic report was commissioned but it was not received until October 2006. It concluded that the injuries were unlikely to be non-accidental and that more information was needed to evaluate the original report.

There had been little further investigation and several of the 2004 report's recommendations had not been addressed. The incidence of fractures has not changed substantially but comparison with other hospitals is not possible at present. The inquiry team identified a number of potential

risks to residents and concluded that the safety and welfare of residents had not been given sufficient priority

Section 24: Future service provision

A five year plan (2006-2010) had been agreed locally, aimed at closing long stay wards and developing community services. Assessment of residents, to inform discharge planning, had commenced. One ward closed at the end of 2007, following the opening of a hostel, which had been long delayed by an industrial relations problem. Few of the objectives of the first two years of the five year plan had been achieved. The plan is to be incorporated into the HSE implementation plan for *A Vision for Change* but this is not clear on how quickly change will take place and funding is uncertain.

Closure of long-stay beds should release funds for new services but this depends on effective cooperation between the HSE, staff organisations and other agencies. Clinical teams need additional staff, particularly community nurses and occupational therapists and an intellectual disability team is required. Reduction in admission bed numbers will require major changes in the management of emergencies.

Section 25: Recommendations

These cover compliance with legal requirements and the need for plans for service development, informed by service users' views, and with clear implementation targets.

1. INTRODUCTION

1.1 The Mental Health Commission, an independent statutory body, was established in April 2002, under the provisions of the Mental Health Act 2001. Section 33(1) of the Act states *"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."*

1.2 The Commission had been concerned about the care and treatment of mental health service users in South Tipperary for some time. Most, but not all, of the concerns are recorded in the reports of the Inspector of Mental Health Services. The 2006 report states:

"The provision of mental health services in South Tipperary was of concern to the Inspectorate throughout 2005 and 2006 and these concerns have been outlined repeatedly to the local health manager and senior management team by the Mental Health Commission. Progress continues to be very slow in both community developments and in the care and treatment of long-stay patients. The Inspectorate continue to be concerned at the lack of progress towards closure of the hospital, the lack of development of community teams and facilities, the lack of care planning, the absence of a rehabilitation team, the continued admissions to long-stay wards and the lack of therapeutic activities for long-stay patients and for acutely ill patients. There must be a concerted effort both on the part of the clinical staff and local health manager to rectify these deficiencies and provide an acceptable level of care both for patients with enduring mental illness and for service users in the community. The Inspectorate will continue to monitor the progress in all areas in 2007."

"There are no dedicated mental health teams within the intellectual disability service and no advance has been made on the situation outlined in the Inspectorate reports of the past two years. The provision of the existing scant service is dependant on informal liaison between the psychiatrists themselves, and with general adult mental health teams. The lack of services has resulted in lengthy and inappropriate admissions of persons with intellectual disability to general adult mental health units and a lack of appropriate therapeutic care."

1.3 The Commission identified four additional areas of concern:

- The environment at St. Luke's Hospital

- The use of seclusion and the locking of wards

- The incidence of injuries to residents, mostly unobserved

- The notification to the Commission of the admission of children

1.4 The Commission therefore decided, at a meeting held on 26th June 2007, to establish an inquiry under Section 55 of the Mental Health Act 2001 to investigate these concerns. The terms of reference of the inquiry were *"To review care and treatment practices in St. Michael's Unit, South Tipperary General Hospital, Clonmel and St. Luke's Hospital, Clonmel, including the quality and planning of care and the use of restraint and seclusion and to report to the Mental Health Commission".*

1.5 The Commission appointed the following to conduct the inquiry:

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

Ms. Maeve Kenny, Assistant Inspector of Mental Health Services, Mental Health Commission

Dr. Adrian Lodge, Medical Commissioner, Mental Welfare Commission for Scotland

Mr. Jamie Malcolm, Nurse Commissioner, Mental Welfare Commission for Scotland.

Dr. Adrian Lodge and Mr. Jamie Malcolm were appointed Assistant Inspectors of Mental Health Services as per Section 54 of the Mental Health Act 2001 solely for the purposes of this Inquiry. Dr Adrian Lodge was appointed Chair of the Inquiry Team.

Ms. Colette Ryan, Mental Health Commission, provided administrative support.

Mr. Des McMorrow is a mental health nurse and has worked in a variety of clinical areas. He has been involved in managing hospital closure and resettlement and conducting inquiries in Ireland.

Ms. Maeve Kenny is a principal clinical psychologist practicing in adolescent and adult mental health. She has worked in learning disability and child mental health services.

Dr. Adrian Lodge was formerly a consultant psychiatrist in Edinburgh. He has worked in adult general psychiatry, rehabilitation and learning disability and has experience of hospital closure and resettlement.

Mr. Jamie Malcolm is a nurse commissioner at the Mental Welfare Commission for Scotland and has an extensive background within mental health nursing and management.

Dr. Lodge and Mr. Malcolm have chaired inquiries carried out by the Mental Welfare Commission for Scotland.

1.6 The terms of reference agreed by the Commission were those of a general inquiry. The inquiry team agreed to examine current care and treatment practices with particular reference to the Mental Health Act 2001 and its regulations, rules and codes of practice and to assess the plans for future care provision against the policies and guidance set out in *A Vision for Change* and the Commission's *Quality Framework*. The team agreed that the quality of care received by service users would be central to the inquiry. A detailed analysis of the funding of the service was not part of the remit of the inquiry.

1.7 The inquiry team was not asked to investigate any specific incidents or allegations. It was agreed at the outset that if information were received, during the conduct of the inquiry, which would potentially lead to the criticism of an individual, the team would consult the Commission regarding the most appropriate action. This did not prove necessary.

1.8 Section 51.(2) of the Act gives the Inspector of Mental Health Services and assistant inspectors appointed under Section 54.(2) and (3) certain powers, when carrying out an Inquiry under Section 55. Reference should be made to the Act for precise details. The inquiry team received full cooperation from all parties and these powers were not used.

2. METHOD AND PROCESS OF THE INQUIRY

2.1 The first meeting of the Inquiry Team was held on 25th July 2007. The team agreed on the matters that were to be investigated and on an outline procedure for the conduct of the inquiry. As a first step the team identified local service documents (app. 1) that were relevant to the inquiry. A request for copies of these was made to the senior management team at St. Luke's Hospital. This request was complied with promptly and the team studied the information before the first visit to the hospital.

2.2 The team visited St. Michael's Unit and St. Luke's Hospital, Clonmel, during the week beginning 20th August 2007. Preliminary meetings were held with representatives of the Psychiatric Nurses' Association (PNA), the Irish Nurses' Association (INO), the Services, Industrial, Professional and Technical Union (SIPTU), the Irish Hospital Consultants' Association (IHCA) and the Irish Municipal, Public and Civil Trades Union (IMPACT) on 21st August 2007, to explain the purpose and intended conduct of the inquiry. This was set out in a brief paper (app. 2), which was made available to those who attended. The Irish Medical Organisation (IMO) was consulted but was unable to attend a meeting. Representatives of all the organisations indicated that they accepted the reasons, and the method to be adopted, for the inquiry. They anticipated that their members would cooperate fully with the Inquiry Team. The team also met the Local Health Manager and the senior management team of St. Luke's Hospital, comprising the Clinical Director, Hospital Manager and acting Director of Nursing. They indicated that they would cooperate fully with the inquiry and make all necessary arrangements to facilitate the work of the inquiry team. A verbal and written explanation (app. 2) of the purpose and intended conduct of the inquiry was provided and this was accepted.

2.3 Visits were made to the male and female wards at St. Michael's Unit and the seven wards at St. Luke's Hospital on 22nd - 24th August 2007. Relevant information was obtained from the nurses in charge and the wards were briefly inspected. Clinical records, including prescription charts, observation and seclusion records were examined, as was considered appropriate, although the scope of the inquiry precluded examination of all records. Those residents who were willing to meet members of the team were interviewed and their medical and nursing records were examined. The information was recorded in a structured format (apps. 3&4), which was developed from forms originally designed for the Mental Welfare Commission for Scotland. Some opinions, expressed by residents and by members of staff, are contained in this report. The opinions of residents appeared to the inquiry team to be genuinely held, rather than manifestations of mental illness or intellectual disability. Information from other sources, relevant to these opinions, is provided, where this was available. The main focus of the inquiry was the overall quality of the care provided to residents, not the specific care of individual residents.

2.4 During the course of this visit the team identified those individuals and groups it wished to meet during the second visit to the hospital. Members of staff were informed of the option to meet the inquiry team privately. A confidential telephone line was set up at the Mental Health Commission and meetings were arranged with individuals. These were held during the second visit to Clonmel, at a local hotel.

2.5 The team next met on 18th September 2007. The inquiry team met the former Regional Risk Manager for HSE South . She provided copies of correspondence and personal notes to support her verbal account. The information obtained during the August visit was reviewed and the timetable for the second visit to local services, during the week commencing 8th October 2007, was drawn up. It was agreed at this time that the inquiry report should describe hospital and community services. In addition a number of general themes were identified, which are set out in the report. Following this meeting invitations were sent, to individuals and groups, to meetings to be held during the October visit and a further list of documents and other information (app. 5) that the team required was sent to the senior management team.

2.6 During the October visit the wards were revisited to confirm and add to the information previously obtained. The major community based facilities were visited and briefly inspected. These included community team bases, day hospitals, day centres, hostels and supported accommodation. Meetings were held with the following:

- Assistant National Director, HSE South, PCCC Directorate
- Local Health Managers of South and North Tipperary
- Acting Director of Nursing
- Clinical Director
- Hospital Manager, St. Luke's Hospital
- Members of the clinical teams for East and West Clonmel and Tipperary
- Members of the child and adolescent psychiatry clinical team
- Members of the psychiatry of later life clinical team
- Members of the rehabilitation clinical team
- The Consumer Panel
- Consultant psychiatrists
- Clinical psychologists
- Social workers
- Occupational therapists
- Assistant directors of nursing
- Clinical risk managers
- Representatives of GROW

A second meeting with representatives of the Psychiatric Nurses' Association was held at their request. All those interviewed were provided with a copy of a 'Process Document for

Interviews', which outlined the basis and format of the inquiry (app.6). The consultant psychiatrists, clinical psychologists, social workers, occupational therapists and the Psychiatric Nurses' Association made written submissions to the inquiry team.

2.7 Records of the meetings with individuals and groups were made and those interviewed were given an opportunity to correct and to comment on the record of their meeting, as outlined in the 'Process Document for Interviews'. All those interviewed indicated agreement with this procedure at the beginning of their interview. The draft report was adjusted, where appropriate, to take account of the corrections to and comments on their interview record, provided by those who had been interviewed. The corrections and comments were retained with the records of the individual meetings.

2.8 The team met again on 8th/9th November 2007 and on 12th/13th December 2007. Following the second meeting, a draft of the factual information, which would form the basis of the report, was produced. This was passed to the Local Health Manager, with a request that he consult with the senior management team and relevant individuals, for the identification of any errors or inaccuracies.

2.9 A request to comment on the draft report was made earlier by the Psychiatric Nurses' Association. The hospital consultant psychiatrists' group later expressed concern that they were unable to comment directly to the inquiry group and that they had no opportunity to review the local response after it had been coordinated by the Local Health Manager. The Local Health Manager indicated, subsequently, that he and HSE South had expected to have an opportunity to comment on the full draft report. At the next meeting of the inquiry team, on 29th/30th January 2008 comments received from the local Health Manager, regarding the draft of factual information, were reviewed and appropriate amendments made to the draft inquiry report. At this meeting the inquiry team decided to adopt a two stage consultation process. All the trade unions and professional associations that were consulted at the outset of the inquiry, together with the Irish Advocacy Network, would be given an opportunity to comment on the draft of factual information. Subsequently these organisations, together with HSE South and the local senior management team, would be given an opportunity to comment on the draft comments, findings and recommendations of the inquiry report. The inquiry team considered that the combination of the opportunity for those interviewed to correct the record of their interview, together with the opportunity for parties to the inquiry to correct the draft factual record and to comment on the comments, findings, recommendations and conclusion of the draft report was the arrangement that was fairest to individuals and to the parties to the inquiry and this was in keeping with the principles of natural justice.

2.10 Drafts of the factual information in the report were circulated to the relevant organisations in early February 2008. All comments received were reviewed at the next inquiry team meeting, on 27th/28th February 2008 and appropriate amendments made to the draft report. A substantial number of factual changes to the text of the draft report, proposed by various organisations and persons, were, in the opinion of the inquiry team, an expression of opinion or contentions with regard to the facts, which the inquiry team declined to accept.

2.11 The Local Health Manager and HSE South, through its legal representatives, expressed a number of concerns about the draft report. These included concerns about:

- the accuracy of parts of the report
- comments on the prescribing of benzodiazepines
- the fairness of the inquiry procedure to individuals, unnamed but identifiable in the report
- the omission of information from the Report of the Inspector of Mental Health Services 2007 to balance the extracts from the 2006 report, already included in the draft inquiry report
- the proposal to consult with members of staff through professional associations and trade unions before finalisation of the report

Following a request from HSE South, the amended draft report, which included the comments, findings, recommendations and conclusion, was forwarded to HSE South for comment in early April 2008. Submissions with regard to the facts contained in the draft report were received from HSE South at the end of April and the inquiry team provided the Local Health Manager with a detailed response and a revised draft report at the end of May. Following further correspondence with HSE South, through its legal representatives, the inquiry team offered to include a submission, as an appendix to the inquiry report, setting out the HSE concerns but this offer was not taken up.

2.12 The Annual Report (2007) of the Mental Health Commission, including the Report of the Inspector of Mental Health Services 2007, was published in May 2008. This included an inspection report of South Tipperary mental health services, which had been carried out in November 2007. The inquiry team agreed to the request from HSE South that extracts from the

2007 report should be inserted into the inquiry report, being more up to date than the extracts from the 2006 report that were quoted in the draft inquiry report. The conclusions from the 2007 report, equivalent to those from the 2006 report, which were quoted in section 1, have been added to the comments in sections 4 and 21 of this report. The other equivalent extracts from the 2007 report have been added to the comments in the sections of this report where extracts from the 2006 report were already included.

2.13 The inquiry team accepted a proposal from HSE South to modify the intended circulation of the draft report to professional organisations, trade unions and the Irish Advocacy Network. Copies of the draft report, amended as described above, were sent to named members of staff, where this was possible, and the relevant sections, rather than the full report, were circulated, where appropriate.

2.14 All comments received in response to this circulation were reviewed at the next inquiry team meeting, on 3rd July 2008, and appropriate amendments made to the draft report. Again, a substantial number of factual changes to the text of the draft report, proposed by various organisations and persons were, in the opinion of the inquiry team, an expression of opinion or contentions with regard to the facts, which the inquiry team declined to accept.

2.15 The inquiry team provided a copy of the revised draft report to the HSE, to allow it to consider a final submission. However, the section of the draft report concerned with injuries to hospital residents was withheld at this time. This was because of comments received from consultant psychiatrists, which included information regarding a meeting that was held on 15th July 2005 to consider a report on injuries to residents. The meeting and related events are described in detail in section 22. The inquiry team considered that the information appeared to suggest that there may have been an attempt to suppress wider circulation of important information. The inquiry team decided that clarification of this matter was necessary and therefore arranged to interview or obtain written information from those who attended the meeting. Two consultant psychiatrists took part in a telephone interview with the inquiry team and the members of the team met the Hospital Manager, former Regional Manager, former acting Regional Manager and Director of Nursing. A draft extract of the inquiry report, covering the meeting of 15th July 2005 and related matters, was circulated to all these individuals and the former Regional Risk Manager for comment. Appropriate amendments were subsequently made to the draft inquiry report. As a result of this process the inquiry team now believes that nothing improper occurred and the account given in section 22.3 is an accurate reflection of events at that time.

2.16 The additional interviews, the associated checking of records and revision of the draft inquiry report and the two stage consultation process, described in 2.9 above, delayed completion of the inquiry for a considerable time.

2.17 The revised section 22 of the draft report was sent to the HSE in December 2008 in order that it could decide whether to make a final submission but it did not accept this proposal. The inquiry team held its final meeting on 19th/20th January 2009 and agreed the final inquiry report. This was presented to the Mental Health Commission at a meeting on 29th January 2009.

2.18 The findings of this report are based on the facts contained in the report and the recommendations are derived from the findings. The most recent assessments carried out by the inquiry team, at St. Luke's Hospital and St. Michael's Unit, were in October 2007. More recent changes in service provision have been notified to the inquiry team and these are mentioned in the report but the inquiry team was unable to assess them. This report contains extracts from relevant recent reports, such the annual report of the Inspector of Mental Hospitals (2007) and the second report on implementation of the Independent Monitoring Group on *A Vision for Change.*

3. BACKGROUND

3.1 As stated in the introduction, the inquiry team agreed to examine current care and treatment practices in St. Michael's Unit and St. Luke's Hospital with particular reference to the Mental Health Act and its regulations, rules and codes of practice and to assess the plans for future care provision against the policies and guidance set out in *A Vision for Change* and the Commission's *Quality Framework*. The team agreed that the quality of care received by service users would be central to the inquiry. Most of the concerns about the services are recorded in the annual reports of the Inspector of Mental Health Services in 2005 and 2006. These documents are summarised below and are referred to in other sections of the inquiry report, where relevant.

3.2 Mental Health Act 2001

3.2.1 The Mental Health Act 2001 provides the legislative framework for mental health services. The sections of the Act cover, in particular, arrangements for involuntary admission, independent review of detention, consent to treatment and approved centres. Section 63.(1) of the Act requires that inpatient facilities for the care and treatment of people with mental illness must be registered and have a named person responsible for them. At the time of the inquiry the Local Health Manager was the registered proprietor. In February 2008 HSE indicated it would be the registered proprietor. Section 64.(1) of the Act requires the Mental Health Commission to keep a register of such inpatient facilities, which are referred to in the Act as approved centres. The Act sets out the requirements for registration and the possible sanctions if the requirements are not met. Section 55 sets out the responsibility of the Commission to inquire into *"the carrying on of any approved centre or other premises in the State where mental health services are provided"*. The powers of the inquiry team are set out in Section 51 of the Act.

3.3 Regulations

3.3.1 The Act required regulations to be made, under Section 66, to ensure proper standards and the proper conduct of centres. Under Section 66.(3) of the Act it is an offence to refuse or fail to comply with the regulations and possible penalties are described. The *Mental Health Act 2001 (Approved Centres) Regulations 2006* (S.I. No. 551 of 2006) were issued by the Department of Health and Children in accordance with sections 5.(1) and 66.(1) of the Act and came into effect on 1st November 2006. The regulations cover areas such as general care and welfare, care of residents, staffing, and records, among other provisions. There are 36 regulations and those with particular relevance to the inquiry are outlined in relevant sections of this report. For details of the regulations refer to the *Mental Health Act 2001 (Approved Centre) Regulations 2006.* (S.I. No. 551 of 2006)

3.4 Rules

3.4.1 Section 59.(2) of the Act obliged the Mental Health Commission to make *Rules Governing the Use of Electro-Convulsive Therapy*. The inquiry team did not examine the use of electro-convulsive therapy, as it was not an area of concern that had been highlighted in the annual reports of the Inspector of Mental Health Services. Section 69.(2) obliged the Commission to make *Rules Governing the Use Of Seclusion and Mechanical Means of Bodily Restraint.* The rules on seclusion are referred to in more detail in section 18 of this report. The rules on the use of seclusion and restraint came into effect on 1st November 2006.

3.5 Codes of Practice

3.5.1 The Commission issued two codes of practice on the 1st November 2006. The *Code of Practice Relating to Admission of Children under the Mental Health Act 2001* is referred to in section 23 of this report. The *Code of Practice on the Use of Physical Restraint in Approved Centres* is referred to in section 18 of this report. Section 1.2 of the codes of practice describes their status as follows. "*The Act does not impose a legal duty on persons working in the mental health services to comply with codes of practice, but best practice requires that they be followed to ensure the Act is implemented consistently by persons working in the mental health services. A failure to implement or follow this code could be referred to during the course of legal proceedings*."

3.6 A Vision for Change

3.6.1 In 2006 an expert group on mental health policy published *A Vision for Change,* which set out a comprehensive policy framework for mental health services in Ireland over a seven to ten year period. The Government adopted the document as national mental health policy. A consultation process identified the following core values that underpin the policy:

- *"Services should be person centred and adapted to each individual's needs and potential.*

- *Services should be delivered by skilled professionals working together in community-based multidisciplinary teams, where the contribution of each member is valued and where skills and expertise are combined to design and deliver integrated care plans.*

- *The range of interventions offered should be comprehensive and should reflect best practice for addressing any given mental health problem.*

- *A 'recovery' approach should inform every level of the service provision so service users learn to understand and cope with their mental health difficulties, build on their inherent strengths and resourcefulness, establish supportive networks, and pursue dreams and goals that are important to them and to which they are entitled as citizens"*

3.6.2 *A Vision for Change* recommends strong partnerships between service users and carers and mental health services, particularly in relation to individual care plans, referred to in section 16 of this report, and between mental health services and other statutory or voluntary agencies providing services in the area e.g. housing, primary care, vocational training. The policy outlines a framework for the organisation of service delivery, recommending that specialist expertise is provided by community-based multidisciplinary teams, working across the lifespan. "*CMHTs should serve defined population and age groups and operate from community-based mental health centres in specific sectors throughout re-configured mental health catchments areas. These teams should assume responsibility for self-governance and be accountable to all their stakeholders, especially service users, their families and carers. Some of these CMHTs should be established on a regional or national basis to address the complex mental health needs of specific categories of people who are few in number but who require particular expertise*." *A Vision for Change* includes indicative recommendations about the numbers and types of community mental health teams required per head of population and also outlines the composition and function of community mental health teams, which are referred to in sections 19, 21 and 24 of this report.

3.6.3 Specific recommendations are made about the management and organisation of mental health services. The policy recommends that, while most services are currently managed by the Clinical Director, the Director of Nursing and the Hospital Manager, this system of management now needs, "*to be enhanced to take on board the development and integration of increasingly dispersed, multidisciplinary, specialist mental heath services in larger catchment areas*."

3.6.4 The policy acknowledges that providing a high quality mental health system, as outlined in *A Vision for Change* will require substantial funding and investment. It recommends that the considerable equity in buildings and lands could be realised to fund this plan. The report of the expert group recommends the closure of all mental hospitals and re-investment of released resources into mental health services. For more detailed information about these recommendations and others refer to *A Vision for Change*.

3.7 The Quality Framework for Mental Health Services (2007)

3.7.1 While the regulations set out the minimum standards required from inpatient mental health services, the *Quality Framework for Mental Health Services in Ireland* (2007) goes into more detail in relation to continuous quality improvement in mental health services. "*The implementation of the quality framework is a critical success factor that must be adhered to if mental health services are going to transform and provide a modern mental health service as described in the current national mental health policy entitled A Vision for Change.* The Quality Framework identifies 24 standards and recommends that 14 of those, which incorporated requirements under the regulations, be commenced in 2007 (app. 7). These 14 standards cover areas that were central to the inquiry, such as care planning, service user involvement and clinical governance. Standard 1.1 Individual Care Plans and Standard 1.5 Therapeutic Services and Programmes are referred to in sections 16 and 17, respectively, of this report. During 2007, mental health services should have begun to address each of these 14 standards and to set realistic timeframes for full compliance, while approved centres were required to comply with the minimum standards of the regulations from 1st November 2006. For more detail refer to the *Quality Framework for Mental Health Services in Ireland* (2007)

3.8 Annual Report of the Inspector of Mental Health Services

3.8.1 Sections 50-52 of the Mental Health Act 2001 outline the role, functions and duties and the Inspector of Mental Health Services, which includes visiting and inspecting every approved centre at least once annually (Section 51.(1)(a)), carrying out a national review of mental health services and furnishing a written report to the Commission (Section 51.(1)(b)). The general concerns of the inspector from 2005 and 2006, in relation to South Tipperary mental health services, were outlined in section 1 of this report. The *Annual Report of the Inspector of Mental Health Services 2006* made specific recommendations with regard to St. Luke's Hospital, St. Michael's Unit, South Tipperary mental health services and the specialist mental health services, covering intellectual disability, children and adolescents and rehabilitation, and expressed concern that previous recommendations by the inspector and recommendations from *A Vision for Change* had not been addressed. These recommendations are referred to in relevant sections of this report. For more details refer to the *Annual Report of the Inspector of Mental Health Services 2006*.

4. CURRENT SERVICE PROVISION

4.1 This section describes the development of mental health services in South Tipperary and service provision at the time of the inquiry team visits.

4.2 History

4.2.1 The first patients were admitted to the newly built St. Luke's Hospital in 1835. At that time it was the district asylum for the North and South Ridings of Tipperary. The exterior of the old part of the hospital has changed little since that time. The buildings that are now St. Paul's ward and St. Mary's ward and Edel Quinn House were built in the early 20th century. By the middle of the century the number of residents was nearly 1,000. This number has reduced substantially since then and in 2006 the total number of residents of St. Luke's Hospital and St. Michael's Unit was 192. However, this was the highest level of inpatient provision in Ireland at the time. It was more than double the national average, when allowance was made for residents from outwith the catchment area. There were 134 residents in St. Luke's Hospital and 49 in St. Michael's Unit at the time of the first inquiry team visit.

4.2.2 St. Michael's Unit was built in 1968, on the adjacent South Tipperary General Hospital site. It was the first acute psychiatric unit on a general hospital site in Ireland. In 1971 health service reorganisation split North and South Tipperary mental health services between the Mid Western and South Eastern Health Boards. The Boards agreed to separate the services gradually but North Tipperary patients still account for one in three admissions to St. Michael's Unit. About 30 residents of St. Luke's Hospital and a number of residents in local community houses are from North Tipperary.

4.2.3 The Meehan complex, the building that comprises St. John's, St. Kevin's and St. Bridget's wards, came into service in the 1980s. One ward in the original hospital building, St Catherine's, closed recently and the space has been converted to administrative use. St. Teresa's and St. Clare's wards are the only remaining wards in the original hospital building.

4.2.4 The provision of community services has commenced in recent years and there are currently adult mental health teams in East and West Clonmel and in Tipperary. A psychiatry of later life team, a child and adolescent psychiatry team and, very recently, a rehabilitation team have also been established but none had a full complement of staff at the time of the visit. There was no intellectual disability team.

4.3 Current service

4.3.1 Service provision in South Tipperary is described in detail in the *Report of the Inspector of Mental Health Services 2006* (Book 4). The service had not changed substantially at the time of the inquiry team visits. Changes that took place before the completion of this report are described in the relevant sections. The 2006 census gave the population of Tipperary as 149,244 and South Tipperary as 83,221. A summary of the service at the time of the visits is given below.

4.4 General adult service

4.4.1 Three community mental health teams cover South Tipperary; East and West Clonmel and Tipperary. Referrals to the teams came from general practitioners, St. Michael's Unit and through liaison. The Clonmel teams shared accommodation (Coolgreaney House) in the town, which was acknowledged to be too small. The East team held outpatient clinics in the local general hospital, where there was no administrative support. Outpatient files (there were separate inpatient files) were kept there, one of several locations where files were stored. The Tipperary team had accommodation on the edge of the town, shared with PCCC health centre services. There was a day hospital (St. Vincent's) there and supported accommodation on the same site. A new base and day hospital have been built for the team in Cashel. The three teams held outpatient clinics and provided other services in the team bases, such as clozapine clinics and anxiety management groups. Some outpatients were also seen at St. Michael's Unit. None of the teams included an occupational therapist and the West Clonmel team had only sessional input from a clinical psychologist. The most appropriate skill mix of nurses in the teams was not agreed but was under discussion. There was a day centre in Clonmel (Morton St. – 20 places) and in Tipperary (Cuan Croi – 18 places). In Clonmel the local voluntary group ran the Cluain training centre. It was partly funded by HSE and provided rehabilitation, sheltered work and vocational training for 70 trainees.

4.4.2 There was a range of supported accommodation in South Tipperary. The community teams provided the support but there was a plan for the rehabilitation team to take over this responsibility. There was a high support hostel in Tipperary (Mount Sion – 18 places). A second high support hostel at Cashel (10 places, two for respite care) had been built but its use was delayed by an industrial relations problem. There was a low support hostel (Rocklands – eight places) in Tipperary and there were another three low support residential places there. Edel Quinn House was a medium support hostel (10 places) in the grounds of St. Luke's Hospital and there were 30 low support residences in Clonmel, many in the hospital grounds.

4.4.3 St. Michael's Unit had wards for male and female admissions. In 2006 there were 668 admissions, including 83 who were detained. 30 of those admitted were over 65 and two were under 16. Over one third of the admissions came from North Tipperary, which is part of HSE West but has no local admission facility. About one per cent of patients admitted were not Tipperary residents. Over two thirds of admissions took place outside normal working hours. The unit was often full and sometimes patients had to wait for admission. Two nurses were employed in a pilot of home-based treatment in the West Clonmel team but it was not clear whether this would reduce the need for admissions.

4.5 Rehabilitation

4.5.1 A consultant psychiatrist (0.5wte approx.) and an occupational therapist had been appointed. A clinical psychologist (0.2wte) attended team meetings and was treating a few residents but there was no social worker in the team. The main focus of work was St. Teresa's ward, where a rehabilitation programme was being developed for the residents, who were nearly all long-stay hospital residents.

4.5.2 Nursing staff ran an occupational department in the hospital grounds. This was originally an industrial therapy unit and work-orientated activity remained an important component, along with social and recreational activities. Residents received a small payment.

4.6 Intellectual disability

4.6.1 There was no intellectual disability team. A residential service for those who were not in hospital was provided by a voluntary agency, which had access to specialists, through a service level agreement. The mental health service could arrange admission to St. Michael's Unit in an emergency. There was no separation of the accommodation in St. Luke's Hospital for residents with intellectual disability and for those with mental illness.

4.7 Continuing Care

4.7.1 There were seven wards in St. Luke's Hospital. Long-stay residents with intellectual disability and residents with mental illness were cared for in St. Kevin's, St. Bridget's, St. John's, St. Paul's and St. Clare's wards. Older residents were cared for in the latter two wards. A detailed description of these wards is given in later sections. In 2006, 100 patients were admitted to the seven wards, including 18 who were detained. 28 of those admitted were over 65, none was under 16. In the first six months of 2007 there were nine admissions.

4.8 Psychiatry of later life

4.8.1 Clonmel was the base for this team and clinics were held there. The clinical staff included a consultant psychiatrist, non-consultant hospital doctor (NCHD), two clinical nurse specialists and an occupational therapist (part-time). Referrals came from local general, geriatric and community hospitals and from general practitioners, including referrals from over twenty nursing homes that were within the catchment area. If admission was required, this was to St. Michael's Unit. Long-term care was provided in St. Mary's ward. About half the residents there were previously long-stay residents of the hospital because of long-term mental illness.

4.9 Child and adolescent psychiatry

4.9.1 The team consisted of a consultant psychiatrist, clinical psychologist, social worker, NCHD and a nurse, who was on a temporary contract. In addition there was a consultant psychiatrist (0.4wte) on a limited temporary contract. A service was provided for young people up to age 16. The work was community based; there was no inpatient provision. If safety was a serious concern, admission to a child and adolescent unit or, failing that, a paediatric ward would be sought. Admission to St. Michael's Unit could be arranged as a last resort. Children admitted there were under the care of the relevant adult team. In appropriate cases, the child and adolescent team was available to support young people who were admitted there. Referrals to the team came from general practitioners but there was a delay of six or seven months before routine cases were seen. Urgent cases were seen within 24 hours. Eating disorders, psychosis, major depression, suicidal preoccupation and obsessive-compulsive disorder were the problems that were given highest priority.

4.10 Service management

4.10.1 St. Luke's Hospital and St. Michael's Unit are approved centres under the Mental Health Act 2001. At the time of the inquiry the Local Health Manager was the registered proprietor and was responsible for the operation of mental health services. The role of registered proprietor has made a substantial change to the responsibilities of the Local Health Manager. He was also responsible for primary, community and continuing care services in South Tipperary, which was a much larger budgetary responsibility. Day to day running of the approved centres was the responsibility of the senior management team, comprising the Hospital Manager, the Clinical Director and the acting Director of Nursing. Management of the service was complicated by the location of St. Michael's Unit on the general hospital site. Arrangements for works and maintenance were shared between the two hospitals.

4.10.2 South Tipperary consultant psychiatrists wrote to the Local Health Manager on 10th October 2006, setting out a large number of concerns they had about the care of residents of St. Luke's Hospital and St. Michael's Unit and the level of current community service provision, requesting a meeting to discuss these matters. They subsequently met the Local Health Manager and the Hospital Manager in February 2007. They expressed their view that the perceived deficiencies were the result of longstanding underfunding.

4.11 Service funding

4.11.1 A detailed analysis of the funding of the service was not part of the remit of the inquiry, although the level of funding is one of the principal determinants of the level and quality of service provision. The inquiry team did not have up to date financial information but information from earlier reports of the Inspector of Mental Hospitals indicated that the service was, per capita, among the least well funded in the region. The sharing of services between North and South Tipperary complicates interpretation of this information.

4.11.2 The inquiry team was provided with information on spending on the local service but this is not included in the report as it would not be meaningful without proper financial analysis. Professional staff and organisations expressed a belief that the service was deficient in many respects and was seriously underfunded, although they did not have comprehensive financial information. Professional organisations stated that they had raised this with managers in the past and consultant psychiatrists provided copies of correspondence on this subject, dating back to 2006.

4.11.3 Concern was expressed to the inquiry team by professional organisations that there was disproportionate expenditure on the administration department. The department had been refurbished recently and appeared modern and in good decorative order, in contrast to ward areas, but the level of refurbishment did not appear inappropriate.

4.12 Comment

4.12.1 Although the Meehan Complex was built in the 1980s, the ward interiors are similar in design to those built earlier in the century. The timing of its building was probably unfortunate, as it coincided with a rejection of the provision of long term hospital care in favour of community care. It is likely that critically reviewing the need for long term care was not a high priority for some time after the new facility had become available. A five year plan, which includes the closure St. Luke's Hospital, was agreed in 2005.

4.12.2 Separation of mental health services for North and South Tipperary has been the agreed policy for over 30 years but no concrete progress has been made. This inertia affects service planning in South Tipperary. The care and treatment of individuals has been affected as described in this report. Lack of progress towards separation was the most extreme of a number of examples of slow decision making that the inquiry team identified. The inquiry team was informed that, subsequent to its visits in 2007, a committee was established to address this matter.

4.12.3 The care and treatment provided by the existing community services were not included in the inquiry remit. There appeared to be general acknowledgement that there were many gaps in provision, presumably reflecting the level of investment. The state of existing services has clear implications for future service development.

4.12.4 It was clear to the inquiry team that there were differences between managers and professional staff, linked to service provision, the pace of change and to funding. These were also evident in relation to consultation on the report. Members of staff and professional organisations told the inquiry team that they had raised concerns about the service and suggested improvements but these had not led to the changes that they desired.

4.12.5 The Report of the Inspector of Mental Health Services 2007 concluded, *"South Tipperary was primarily a bed-based service with poorly developed community resources for providing real alternatives to acute admission. The closure of St. Luke's Hospital and the resettlement of residents to more suitable accommodation had commenced but was painfully slow. The service had significant nursing resources attached to in-patient care. There was a marked lack of health and social care professionals, especially in relation to occupational therapy. The process of change had commenced but there was a continued need for all staff and HSE management to ensure that all barriers to real change were removed and that clear objectives were met in a timely manner."*

4.13 Findings

4.13 a) Bed numbers have declined substantially in Tipperary but remain very high, relative to other parts of Ireland.

4.13 b) North and South Tipperary are in different HSE regions. This complicates the management and planning of mental health inpatient services, which are jointly provided, despite an agreement, reached over 30 years earlier, that they should be provided separately.

4.13 c) The number of referrals for admission to St. Michael's Unit often exceeded its capacity.

4.13 d) Admissions to long-stay beds in St. Luke's Hospital have virtually ceased. Any admissions are contrary to hospital and national policy.

4.13 e) The wards in St. Luke's Hospital were designed for the provision of institutional care. The buildings are not suitable for the provision of person centred care.

4.13 f) Funding for the development of modern, community based services and specialist mental health services was limited. This was, in part, because of the cost of the provision of long-stay care at St. Luke's Hospital.

4.13 g) Clinical files were often not readily available to clinical staff because they were kept at a number of sites from which the service operated and because there were separate inpatient and outpatient files.

4.13 h) Submissions to the inquiry from professional staff and organisations indicated that concerns about the local service were raised before the establishment of the inquiry but they were not fully addressed.

5. ST. MICHAEL'S UNIT: 22nd AUGUST 2007

5.1 Description of function and admission criteria

This was the admission unit for South and North Tipperary. The male side had 25 beds, the female side 24. There was a policy governing admissions and discharges dated 26th June 2007, which is described in section 15. Five sector teams admitted to the unit.

	Male side	Female side
Total beds	25	24
Male beds	25	0
Female beds	0	24
Male residents	22	0
Female residents	2	25

5.2 Staffing

5.2.1 Medical

There were six consultant psychiatrists and six NCHDs.

5.2.2 Nursing

The agreed staffing levels for each side of the unit were a minimum of five nurses during the day and two at night (2030-0800hrs). However, actual staffing levels were usually higher. Extra staff

was provided if one to one nursing was required. The inquiry team was informed that nursing staff had objected to one to one special observation being carried out by unqualified care assistants. Senior managers pointed out that the introduction of care assistants was by agreement with nursing trade unions. Day staff worked either 0800–2030hrs or 0800-1800hrs. Two nurses, or more, were on duty 1800-0800hrs. On the day of the visit a health care assistant was providing one to one nursing in the male side high observation area. There was a record of staff on duty and in charge of the unit. Nursing staff were often transferred to the unit from wards in St. Luke's Hospital because of staff shortage.

5.2.3 Health and social care

There was no occupational therapy available on the unit, except when requested for residents under the care of the psychiatry of later life team. Input to the unit, by psychologists and social workers, was limited but residents were referred through sector teams.

5.3 The residents

5.3.1 Male side: Twenty of the men had a mental illness and two had dementia. Their ages ranged from 20 to 78 years. On the day of the visit, seven residents were detained and another was on leave. Two residents had been in hospital for over a year. On the day of the visit, two female residents were accommodated on the male side and a third was to be transferred there that night.

5.3.2 Female side: On the day of the visit there were 25 residents. Two residents were on leave. One resident spent the previous night in the seclusion room, although not secluded, following emergency admission after midnight. Arrangements were being made for appropriate accommodation the following morning. Six residents were detained. All residents had a primary diagnosis of mental illness and, on the day of the visit, had been in hospital for less than one year. There were no residents from an ethnic minority and English was the first language of all residents.

5.3.3 15 children under 18 years had been admitted since November 2006; there were none on the day of the visit. It was reported that one to one nursing and single room accommodation was provided for children under 16 years and that arrangements for 16 and 17 year olds were based on clinical assessment of need.

5.3.4 All residents had access to their money. A small amount of money was kept in the ward safe and each resident had an individual account. An individual record was kept by the staff of any deposits or withdrawals, which required the resident's signature. The CNM2 carried out a weekly check on residents' money and it was reported that the ADON carried out checks from time to time. There was no external audit of residents' accounts.

5.3.5 There was a general information leaflet available for residents and relatives. There was an information leaflet about seclusion for relatives.

5.4 Care planning

5.4.1 Multidisciplinary team meetings

Five sector teams could arrange admissions to the ward. Nursing staff commented that the threshold for admission was low and that most admissions took place out of hours. Consultant psychiatrists responded that difficult decisions about admissions, especially late at night, had to be taken, which reflected the real risks, particularly in the absence of alternative supports both within the mental health services and without. None of the teams had a full complement of health and social care professionals. The social worker and psychologist did not attend the weekly clinical meeting of the Clonmel East team that was held on the unit. Medical, nursing and social work staff attended the weekly meeting of the Clonmel West team. All the professional groups attended the regular weekly Tipperary team meeting. Residents from both North Tipperary sectors were under the care of one consultant psychiatrist, who met the primary nurse on weekdays, except Tuesday. There was very limited access to psychologists and social workers for these residents during their admission. The consultants and NCHDs from the rehabilitation and psychiatry of later life teams held ward rounds when there were residents under their care in the unit.

5.4.2 Care and supervision

The general ward areas were open and the high observation areas were locked on the day of the visit. A record was kept of when the doors were locked. There was an observation policy that referred to the locking of the doors and this was under review. 13 of the male residents and 16 of the female residents were on raised levels of observation, requiring them to wear night clothes during the day. This was not recorded as part of their care plan, as required by the Regulations. Six female residents were being nursed in the high observation area and one was being nursed, on a one to one basis, in the general area of the ward. Staff were unable to provide a rationale that was acceptable to the inquiry team for the frequent practice of nursing residents in night

clothes during the day and for the additional restriction of being in the locked high observation area. They said that this was established practice. There was no evidence that alternatives had been considered but the inquiry team was informed that a review of the policy was to be carried out.

Staff reported that residents' belongings were searched on admission and searches had been carried out when there was a suspicion that alcohol was being brought into the unit. Senior managers, in response to the draft factual report, stated that residents were not routinely searched on admission but an inventory of personal belongings was made. There was a policy on searches.

5.4.3 Seclusion

There were seclusion rooms on each side of the ward, with bathrooms nearby, located in the high observation area. There was no direct means of communication from either seclusion room. A clock was not visible from the seclusion room on the male side. The use of seclusion in St. Michael's unit is discussed in more detail in section 18.

5.4.4 Therapeutic and recreational activities

There were no therapeutic activity programmes linked to individual care plans or aimed at rehabilitation. Nursing staff ran an activity programme on the unit. There were sessions most mornings and afternoons. An artist and local VEC staff provided art classes. Generally the programmes were not individualised, except on the rare occasion when a resident was referred for individual work. A recent survey of residents' views on the activities provided is described in section 14. None of the residents attended activities off the ward. Neither of the residents who had been admitted for longer than a year had been on a holiday.

5.4.5 Reviews

There were no individual integrated multidisciplinary care plans. Residents did not have a primary nurse but each sector was allocated a nurse each day. Each resident had a nursing care plan, which was evaluated and reviewed weekly with the resident by the allocated nurse. The nursing care plans that were examined by the inquiry team did not describe specific interventions for addressing assessed needs or achieving specific goals. A recent audit of care plans is described in section 16. The nursing care plans were reviewed at the weekly multidisciplinary team meetings. Staff reported that all residents had an annual physical review. In the files

reviewed, of residents who had been in hospital for longer than six months, there was no evidence of six monthly physical reviews, as required by Regulations.

5.4.6 Records

There were separate medical and nursing files. The psychologists, social workers and occupational therapist recorded notes in the medical file. There were regular progress notes in both the nursing and medical files. Recent contact with medical staff was recorded. Medication records were appropriately maintained.

5.5 Advocacy and support

5.5.1 Staff from the Irish Advocacy Network visited the unit every week and there was a befriending scheme in place. The two female residents interviewed were aware of this. The peer support group, GROW, ran an introductory group to their service and activities every six weeks. There was a South Tipperary mental health services policy on religious and cultural practices.

5.6 Environment

5.6.1 Sleeping areas and personal space

The quality of the environment was poor, with little in the way of soft furnishings. In the high observation areas there was a five bed dormitory and a single room. The areas were in poor decorative condition and, in places, paint was peeling from the walls. The single room on the male side was in particularly poor condition with dirt on the floor and walls, a strong odour and no furnishings apart from a bed frame. The corridor flooring was in poor condition with some parts missing and some lifting. Staff reported that maintenance was generally slow on the unit and repairs could take several weeks or months. One resident was smoking at his bedside. There was no personal space, apart from around the residents' beds, which had curtains. In the general area of the male side there was a dormitory with five beds, overlooked by the nurses' observation office, a dormitory with six beds, two double rooms, one with an ensuite toilet, and four single rooms. Staff reported that female residents were unable to lock their bedroom door, when they were accommodated temporarily on the male side. In the general area of the female side there were two single rooms, two double ensuite rooms and two six bedded dormitories. Each resident had a wardrobe and locker, neither of which could be locked.

5.6.2 Day areas

The day areas were located on the male side of the unit but were shared. There was a television lounge, a quiet room, an activity room and a small office, used for storing activity materials. A small dining room could accommodate 28, although the bed complement of the unit was 49. Residents on raised levels of observation received their meals in their bedrooms. There were no day areas in the high observation areas, apart from the smoking room. The ventilation system did not prevent smoke from entering the rest of the area.

5.6.3 Bathrooms/toilets

Overall there were sufficient toilets and bathrooms. The toilet and shower areas in the high observation area on the male side were in poor condition and the shower control in the bathroom was broken. After the first inquiry team visit, staff reported that a tendering process for upgrading these facilities had begun. When female residents were sleeping on the male side, access, by men, to some of the toilet and shower areas was restricted. On the female side a shower, in the high observation area was in a poor state of repair. It was damp, had no ventilation and water sprayed from the shower onto the floor in the changing area. This created a hazard due to the wet floor.

5.6.4 Access to food and drink

Staff reported that there was a choice of food and special dietary needs were met. There was a machine for obtaining tea and coffee, but this was not accessible to residents in the high observation area. Drinking water was available. There were no other facilities for residents to make a snack or tea or coffee.

5.6.5 Access to outdoor area

There was an enclosed garden area at the front of the unit, with access through the quiet room. An outside smoking area was at the back of the unit. Residents in the high observation area had no unescorted access to outdoor areas.

5.6.6 Access to telephone

There was a public telephone and residents who were not on raised levels of observation were allowed to use their mobiles telephones.

5.6.7 Arrangements for visitors

There was no dedicated visitors' area. Bedrooms and day areas were used for visits. Visiting times were flexible.

5.7 Residents' comments

5.7.1 A male resident in the high observation area described it as being like a prison. The two women who were sleeping on the male side said they were pleased to have smaller bedrooms and to have toilets and bathrooms to themselves and it was quieter. The inquiry team met four residents on the female side of the unit. All complained of having little to do. One spent the previous day smoking and sitting on her bed; another went for a short walk with a nurse but spent the rest of the day looking out of the window. One felt that nurses did not interact much with residents and there should be care assistants. She felt there were not enough nurses and they spent their time in what she referred to as the observation lounge. The ward environment was criticised, the showers were described as, disgraceful and the toilets as poorly maintained.

5.8 Future plans

5.8.1 A separate area in the middle of St. Michael's Unit, for admissions by the psychiatry of later life team, was under consideration. Additional office space, for health and social care professional staff and for people undertaking assessments and meetings prior to tribunals, was also under consideration. A prefabricated building would probably be used.

5.9 Comment

The inquiry team's concerns are described in detail in sections 15 to 24.

5.10 Findings

5.10 a) The number of admissions to St. Michael's Unit often exceeded its capacity.

5.10 b) The imbalance of admissions and beds caused difficulties, including, at times, a need to care for female residents on the male side of the ward and, on at least one occasion, use of the seclusion room as a bedroom.

5.10 c) Shortage of day space made it difficult for residents to find a quiet area or a place to meet visitors, as there was no designated visiting area.

5.10 d) There were no facilities for residents to make drinks or snacks, apart from a vending machine.

5.10 e) The decor of the unit was quite dull and monotonous.

5.10 f) Several of the showers and toilet areas were in poor condition. Completion of maintenance and repairs was often significantly delayed, increasing the risk of injury to residents.

5.10 g) Residents had very different needs, resulting from a range of conditions, including psychosis, self-harm, intellectual disability and dementia, which made it difficult to provide care in an environment that was appropriate and safe.

5.10 h) The locked, high observation dormitories were not suitable places to care for severely mentally unwell residents during the day.

5.10 i). At the time of the inquiry team visit, more than half the residents of the unit were required to wear nightclothes, which the inquiry team considered unjustified and unnecessarily restrictive.

5.10 j) The management of St. Michael's Unit was complicated because up to seven sector and specialist teams, including two from North Tipperary (HSE West), admitted people there.

5.10 k) There were not enough offices or meeting rooms for the multidisciplinary teams.

5.10 l) A system of individual multidisciplinary care planning, based on comprehensive needs assessments, was not in place, although sector teams had the nucleus of a multidisciplinary team and residents could attend clinical meetings.

5.10 m) The interventions specified in nursing care plans were not based on comprehensive needs assessments. There was no effective keyworker system to provide continuity of care.

5.10 n) Nursing staff, who were unfamiliar with the residents and their care, were frequently transferred to the unit from other areas, to cover absences and clinical needs.

5.10 o) The clinical teams had limited health and social care professional staff, reducing treatment options.

5.10 p) There was a virtual absence of therapeutic activities.

5.10 q) Nursing staff and personnel from outside agencies provided a limited programme of mostly recreational activities but this was insufficient to occupy residents for much of the time

6. ST. BRIDGETS WARD: 23rd AUGUST 2007

6.1 Description of function and admission criteria

St. Bridget's ward provided rehabilitation and support for female residents with intellectual disability. There had been no recent transfers or admissions to the ward. The inquiry team was given a list of ward based activities that included a range of clinical and therapeutic activities, such as behaviour and cognitive psychotherapy and an activity of daily living programme. However, these were not routinely available to residents.

Total Beds	13
Male Beds	0
Female Beds	13
Male residents	0
Female residents	13

6.2 Staffing

6.2.1 Medical

The ward operated under the clinical direction of one of the general adult consultant psychiatrists. There was a NCHD and access to an on-call NCHD. There was no input from a consultant psychiatrist with specialist training in intellectual disability and no general practitioner input to the ward.

6.2.2 Nursing

The agreed staffing level for the ward was a minimum of four nurses during the day, although five were sometimes allocated, and two at night (2030-0800hrs). Staff reported there were often only three nurses allocated to the ward. On the day of the visit six were rostered but two were allocated to St. Michael's Unit. Day staff worked either 0800–2030hrs or 0800-1800hrs. Two nurses were on duty between 1800-0800hrs. All nursing staff were RPNs and some were also qualified as general nurses. None were trained in intellectual disability nursing or behaviour therapy. The CNM usually had a 'hands on' role. Frequently, there was a student nurse rostered. Staffing the ward relied on overtime. A primary and secondary nursing system was used on the ward. There was one household staff allocated to the ward during the day. The inquiry team was informed that a number of duties, currently carried out by nurses, could be carried out by support staff.

6.2.3 Health and social care

No health and social care professionals were members of the clinical team. A psychologist was contracted three month's earlier to assess residents with intellectual disability, using the Adaptive Behaviour Scale. He was not a member of the clinical team. A speech and language therapist, based at the general hospital, had seen two residents on the ward. Referral could be made for dietetics, physiotherapy and social work. A chiropodist attended the ward regularly.

6.3 The residents

6.3.1 Five residents had a diagnosis of mental illness and eight had intellectual disability. Many of the residents had high dependency needs and required full assistance with all aspects of daily living. All of the residents were voluntary. The youngest resident was 37 years and the oldest was 68 years. Length of stay ranged from two years to over 20 years. There was one resident from the travelling community. All residents spoke English as their first language.

6.3.2 Two residents managed their own money, although one of them said she did not know how much money she had in her account or how to find this out. Staff reported that residents' accounts were audited annually by the external hospital auditor.

6.3.3 There was a hospital information leaflet but the ward did not have its own information leaflet for residents or relatives.

6.4 Care planning

6.4.1 Multidisciplinary team meetings

The consultant psychiatrist and NCHD attended a weekly meeting with nursing staff and attended at other times when requested. There was no regular clinical commitment from health and social care professionals.

6.4.2 Care and supervision

Staff reported that the ward had been a secure ward in the past and the practice of locking the doors remained. Staff identified a number of residents who were at risk of wandering but locking the doors was not documented as part of any resident's care plan. Staff reported that raised levels of observation were not used and that there had been no recent searches in the ward. Five residents were prescribed benzodiazepines (mostly lorazepam) long-term at the time of the visit. Good practice guidance, issued in 2002 by the Department of Health and Children states that the need for long term prescribing should be reviewed regularly and that, "the only clinical justification for continuing use is dependence. Planned withdrawal of patients dependent on benzodiazepines should be considered. Attempts should be made to improve levels of mental stimulation and physical activity on long stay wards." It is recommended that long acting, rather than short acting, drugs should be used, if long term prescribing is considered necessary.

6.4.3 Seclusion

There was a seclusion room on the ward, which was rarely used. Nursing staff had worked successfully with one resident, who retired to her room when she felt distressed, avoiding the need for seclusion, which had often been necessary in the past. Only one episode of seclusion was recorded since the new Rules, governing the use of seclusion, came into effect.

6.4.4 Therapeutic and recreational activities

There were no individualised programmes of activities. Activities such as exercise, massage and relaxation were provided by nursing staff who had developed these skills. An art teacher from the local VEC attended the ward during term time. Activities were available off the ward but, at the time of the visit, no one attended. There was a minibus available but limited staffing numbers restricted its use for day trips. Some residents had access to a local taxi service. Four residents went home on occasion. During the year some residents had a holiday, accompanied by members of staff.

6.4.5 Reviews

There was no system for routine psychiatric review of the residents; this was done on a needs basis. Some physical examinations were recorded but these were not carried out six monthly, as required by the Regulations.

6.4.6 Records

There were separate medical and nursing files. There were no individual integrated multidisciplinary care plans. Each resident had a nursing care plan, which was reviewed monthly, or weekly if a new issue arose. There were regular progress notes in both the nursing and medical files. Recent contact with medical staff was recorded. Medication records were appropriately maintained.

6.5 Advocacy and support

6.5.1 Residents had access to the hospital advocacy service on request. There was no befriending scheme. Nursing staff reported that there was no policy on religious/cultural practices and they were not aware of the South Tipperary Mental Health Services policy.

6.6 Environment

6.6.1 Sleeping areas and personal space

Some of the eight single rooms did not have curtains on the windows but had old wooden shutters, which could be locked. There were observation panels in the doors and no means of securing privacy from the corridor. In the five-bed dormitory one resident did not have a screen around her bed and she voiced concern about this. It was reported that general maintenance was hard to access and often staff had to ask the ADON to intervene in order to expedite matters. Staff reported that each resident had a wardrobe and locker, and some residents had keys. Following an increase in bed numbers one resident had to share a wardrobe with another and this could not be locked. The rooms were devoid of any personal touches or possessions. One resident commented that the bedrooms were very hot and there was no way of controlling the temperature. Overall, the ward, while recently decorated, was bare and bleak, particularly the bedroom areas, which, by and large, were devoid of personal belongings. There was a high observation area, which was not used. The use of different colours and textures would have made the environment much more attractive.

6.6.2 Day areas

There was a dedicated dining area with a servery and a large day room with a television and board games. There was a small quiet room with a television and there was an activity room and a smoking room, which a resident described as having no air and being stuffy. A training kitchen was used for board games and contained mats and exercise equipment.

6.6.3 Bathroom/toilets

There were several toilet areas on the ward, including a wheelchair accessible toilet. The toilet cubicles could not be locked and a resident expressed concern about this.

6.6.4 Access to food and drink

Residents reported that they had to ask staff for water and hot drinks, although there was a filtered water dispenser on the ward. The training kitchen was not being used on hygiene grounds because there was carpet on the floor. It may have been suitable for use by residents to make hot drinks

6.6.5 Access to outdoor area

There was an enclosed concreted garden area, devoid of colour or stimulation.

6.6.6 Access to telephone

Residents reported that they could access the cordless ward telephone easily but it was difficult to make calls in private as other residents were always around. One resident indicated that she was going to get her own mobile phone.

6.6.7 Arrangements for visitors

The visiting room was outside the locked area of the ward and there was a toilet nearby. Visiting times were flexible.

6.7 Residents' comments

6.7.1 One resident took part in a formal interview. Two others spoke about specific concerns during a walk about on the ward. All three expressed concern about the future of the ward; two said they did not want to leave and one said the ward was not suitable for her. They all complained about the noise in the ward because of other residents shouting and said it was difficult to find a quiet place to get away from it all. One resident reported feeling unsafe on the ward because of other residents. She said she never knew when she might be hit or attacked.

6.8 Future plans

6.8.1 St. Bridget's and St Kevin's wards will be merged, to provide care and treatment for residents with an intellectual disability, until community placements are available. This will follow the opening of the hostel in Cashel and the completion of assessments**.** Ward nursing staff were not members of the amalgamation group and they felt they were not well informed about developments. The inquiry team was informed that an occupational therapist would be allocated to the ward, after the merger.

6.9 Findings

6.9 a) Some residents received benzodiazepines on a long-term basis, which is usually considered to be undesirable. This was, at least in part, a result of a lack of activities and alternative treatment options.

6.9 b) Removing the locks from all the toilet doors was not an acceptable solution to the risk posed by some residents locking themselves in.

6.9 c) Psychological assessments were carried out under a contract, rather than by a clinical psychologist appointed to the multidisciplinary team.

6.9 d) Assessments, using the adaptive behaviour scale, will identify behaviours that may benefit from treatment programmes. Ward based staff have not been trained in the implementation of treatment programmes. Implementation and monitoring of treatment programmes will not be possible without continuing involvement of a clinical psychologist.

7. ST. CLARE'S WARD: 22nd AUGUST 2007

7.1 Description of function and admission criteria

This ward was designated as a long-stay ward for the care of elderly female residents. There were 20 residents, aged between 57 and 99. Admissions to the ward had ceased and the existing residents were being assessed for discharge to other care settings.

Total Beds	20
Male Beds	0
Female Beds	20
Male patients	0
Female patients	20

7.2 Staffing

7.2.1 Medical

The unit operated under the clinical direction of one of the general adult consultant psychiatrists. There was a NCHD and access to an on-call NCHD.

7.2.2 Nursing

The agreed staffing levels were five qualified nurses during the day and two during the evening and night. It was reported that it was usual for there to be four staff during the day and sometimes there were three. Qualified nursing staff time was directed away from resident centred assessment and care by the demands of basic housekeeping tasks.

7.2.3 Health and social care

No health and social care professionals were members of the clinical team. Referral could be made for speech and language therapy, physiotherapy, dietetics and social work but not for clinical psychology or occupational therapy.

7.3 The residents

7.3.1 The primary diagnoses of residents were intellectual disability (five) and mental illness (15). English was the first language of all residents and none were from an ethnic minority group. The most recent admission was in 2005, the earliest in 1941.

7.4 Care planning

7.4.1 Multidisciplinary team meetings

The consultant psychiatrist and nursing staff attended a weekly meeting to review the care of residents. All residents were being assessed for discharge to other care settings. Staff said that seven residents would move by September 2007.

7.4.2 Care and supervision

There were policies on the use of bed rails and lap restraints but no overall policy covering restraint or other limits to freedom of movement. The ward was locked at night for security reasons; otherwise residents had freedom of movement in and out of the ward.

7.4.3 Therapeutic and recreational activities

Five residents had individual programmes of activities and attended the hospital occupational department. Apart from these examples there was little evidence of individual programmes of activities, linked to assessed needs, for residents. There was no occupational therapy available. There were very limited opportunities for holidays away from the hospital. Staff reported that the closure of the hospital shop had limited the opportunity for residents to purchase small items and this was much missed.

7.4.4 Reviews

There were no individual multidisciplinary care plans. Each resident had a nursing care plan. Residents' individual care plans were reviewed but not to a set timetable. There were records of personal care planning and nursing staff said that a key worker system was in operation. Some physical examinations were recorded but these were not carried out six monthly, as required by the Regulations.

7.4.5 Records

Medication records were appropriately maintained. There was a good example of recording the personal likes and dislikes of a resident with impaired communication.

7.5 Access to advocacy

7.5.1 Residents had access to the hospital advocacy service on request but not to the recently introduced befriending scheme. An information leaflet was in the process of being written at the time of the visit and was available at the second visit

7.6 Environment

7.6.1 Sleeping areas and personal space

There were two dormitory areas of 12 and five beds and three single rooms. High dependency residents were cared for in the main dormitory, which had a sitting area adjacent to the nursing office. The five bed dormitory was quite isolated. It was very institutional in appearance, with dull décor, peeling plaster and extensive exposed pipe work. There were no fixed bed screens or curtains in some areas. The floor was in need of repair and presented a trip hazard. There were lockers for each resident; some were lockable and residents could keep their keys. The storage space was very limited for residents. Even in the single rooms this severely limited opportunities to store personal items, such as toiletries, and to personalise areas with photographs and mementos.

7.6.2 Day areas

There were two day areas, a separate dining area and a smoking room. One day area was in the large dormitory. A partly glazed screen separated the other day area from the adjacent corridor. This area was institutional in appearance and lacked any homely feel. The dining area was also very institutional and lacked any domestic appearance. Lighting in the day area was by two fluorescent tubes and the low level of illumination was insufficient for older people or those with impaired vision.

7.6.3 Bathroom/toilets

There was one bath for residents with limited mobility and one shower. There were no wheelchair accessible toilets, which meant that many residents, who could have used accessible toilets, had to use commodes, screened by bed curtains or movable screens. There appeared to be no basins for hand washing, by residents or staff, close to where commodes were used. Bathing facilities appeared stark and institutional.

7.6.4 Access to food and drink

There was a menu system in operation and drinks were provided regularly throughout the day. Comments by residents on the quality of the food varied; some saying it was fine, some not. There was little evidence of residents' likes and dislikes being recorded. However, staff did prepare some personal favourites for residents, such as fruit smoothies. Residents had access to drinking water. There were no facilities for residents to prepare their own hot drinks. There appeared to be limited storage for favourite foods brought in by relatives.

7.6.5 Access to outdoor area

Although it was possible for residents to sit immediately outside the ward in a concreted yard there was no safe garden area, with wide paths and seats, that would be pleasant place to get fresh air and have an opportunity for gardening activities.

7.6.6 Access to telephone

A cordless telephone was available for use by residents. The location of the public telephone did not afford adequate privacy to residents.

7.6.7 Arrangements for visitors

There was a newly created visiting area, which was pleasantly furnished and decorated.

7.7 Residents' comments

7.7.1 Three residents were interviewed. All three said that they mostly felt safe in the ward. Two residents reported that they were treated with respect.

7.7.2 All commented that the ward could be noisy at times. One mentioned being unable to access a telephone without staff being aware. All three said that there should be more choice of meals. Two residents said that they would like to have access to a kitchen to make hot drinks and snacks. All reported positive contact with their consultant psychiatrist but none had received any written information about the ward or their medication or other treatment. Two said they had not been asked what sort of activities they would like.

7.8 Future plans

7.8.1 All the residents of St. Clare's ward were being or had been assessed for relocation to appropriate care settings. Admissions to the ward had ceased. The aim was to close the ward, early in 2008.

7.8.2 Subsequently, the inquiry team was informed that it was likely that residents of St. Paul's ward would be transferred to St. Clare's ward, allowing closure of St. Paul's ward at an earlier date.

7.9 Findings

7.9 a) Provision of disabled access toilets would reduce the need for the use of commodes.

7.9 b) The lighting in the day room was inadequate for older people or those with impaired vision.

7.9 c) The five year plan included an intention to close the ward in 2007/8 but this has been reviewed and the ward will remain open.

8. ST. JOHN'S WARD: 23rd AUGUST 2007

8.1 Description of function and admission criteria

This ward provided care for male residents with a mental illness or intellectual disability. Admission to the ward was by referral to one of the consultant psychiatrists. In previous years there were frequent admissions but, following a recommendation by the Inspector of mental health services in 2005, admissions were reduced. There were six admissions in 2007 prior to the introduction of a policy, in July, prohibiting further admissions. There was one further admission in 2007.

Total Beds	21
Male Beds	21
Female Beds	0
Male residents	21
Female residents	0

8.2 Staffing

8.2.1 Medical

Two of the general adult consultant psychiatrists had unspecified part-time commitments to the ward. The NCHD attended the ward on most days. There was no general practitioner service to residents.

8.2.2 Nursing

There was a record of the staff on duty and in charge. Five registered nurses were on duty at the time of the visit, which was the agreed staffing level. At night the agreed staffing was two nurses. Two additional staff were usually provided because of a need for one to one nursing.

8.2.3 Health and social care

No health and social care professionals were members of the clinical team. Referral could be made for social work involvement.

8.3 The residents

8.3.1 Three residents were detained and their medication was authorised by Section 60 second opinions. 18 residents had a primary diagnosis of mental illness and three had intellectual disability. Nine residents were aged 25-44 and 12 were aged 45-64. Three residents had been in hospital for less than two years, five for two-five years, six for five-ten years, four for 10-20 years and one for over 30 years. English was the first language of all residents and none were from an ethnic minority group.

8.3.2 All residents, apart from one ward of court, could access their money, on request. It was kept in the ward safe. The recent closure of the hospital shop/café had caused problems, as several residents were unable to travel outside the hospital grounds because they were considered to be at risk on the busy road outside the hospital. Hospital managers arranged for a local business to visit the ward and supply items to residents. There was an annual audit of the ward financial management.

8.4 Care planning

8.4.1 Multidisciplinary team meetings

Both consultant psychiatrists had a ward round each week, which was attended by the NCHD and nursing staff.

8.4.2 Care and supervision

Two residents were on raised levels of observation at the time of the visit and one was not allowed to leave the ward. There was a written policy for searches. The inquiry team was informed that searches would normally be recorded but there had been none for over two years. The ward door was always locked; there was no policy for this. It was not clear, from discussion with nursing staff, that there was a need for the door to be locked permanently but there did not appear to be a system for reviewing this.

The medication prescribed for residents appeared to be appropriate, although a comprehensive inspection of the medication records was not carried out.

8.4.3 Seclusion

There was a seclusion room, which had ensuite facilities. There was a seclusion record available on the unit. Episodes of seclusion were appropriately recorded.

8.4.4 Therapeutic and recreational activities

Activities of daily living and leisure activities were organised by nursing staff but there were no individualised programmes. There was no contribution from other professions. Some residents attended the hospital occupational department and there were outings when transport and staff were available. Holidays were organized for five residents during the previous year. Bedtime for residents was 20.00 according to the ward activity programme. The inquiry team was informed that bedtime was from 20.00, not necessarily at 20.00.

8.4.5 Reviews

Some physical examinations were recorded but these were not carried out six monthly, as required by the Regulations.

8.4.6 Records

All residents had an individual nursing care plan that was reviewed every six months. The overall plans were not very detailed and the individual component plans were non-specific. Personal histories of residents were in the process of being brought up to date by the NCHD.

About half had been completed, to a high standard. There were regular progress notes in both the nursing and medical notes. Recent contact with medical staff was recorded. Medication records were appropriately maintained.

8.5 Advocacy and support

8.5.1 Residents had access to the hospital advocacy service on request but not to the recently introduced befriending scheme. The ward had a written policy to facilitate religious and cultural practices. An information leaflet was available for residents and relatives.

8.6 Environment

8.6.1 Sleeping areas and personal space

There were five single bedrooms and three dormitories, two of five beds and one of six beds. The single rooms were small and quite bare, with few personal possessions apparent. Residents who may self-harm or cause damage to furniture and fittings occupied these rooms. Most of the floor space was taken up by the bed, locker and the wardrobe, which could be locked. All the single bedrooms were painted the same colour. There were no curtains and a sliding screen served as a shutter. The floors had vinyl coverings. The rooms were clean. The dormitories had curtains and bed screens that were attractively patterned. The only 'personal space' in the dormitories was what was enclosed by the screens. This space was very limited, only large enough for an iron-framed bed, a locker and a small wardrobe. The floors had grey vinyl coverings. There were a few personal items, such as photographs on lockers. There was a pleasant outlook to the hills to the south.

8.6.2 Day areas

There were three day areas; one was spacious but it had an institutional appearance, with armchairs placed round the perimeter of the room. The institutional appearance was highlighted by a sign suspended from the ceiling above the television, indicating 'TV area'. The room where smoking was permitted had a rather run down appearance, emphasised by a broken sofa. The ward did not feel spacious because of the low ceilings, particularly in the corridors, and the small rooms. The vinyl floors and painted walls appeared cold and institutional, rather than homely. This impression was emphasised by the limited wall decoration and visible personal items. Much of the furniture and fixtures showed signs of wear and tear.

8.6.3 Bathroom/toilets

There was one bathroom that also contained a shower. It had a worn, institutional appearance and was damp. It was the only bathroom for 21 residents and was clearly heavily used. A curtain provided the only privacy in the bathroom. There was adequate privacy in the assisted toilet and in the separate toilet block, which showed signs of wear and tear and could hardly have been less home-like.

8.6.4 Access to food and drink

There was unrestricted access to drinking water but hot drinks were only available at set times. There was no provision for residents to make snacks.

8.6.5 Access to outdoor area

There was a large, neglected looking, enclosed outdoor area that was mainly covered with asphalt, although there were some small trees and shrubs. Entry was from the day room.

8.6.6 Access to telephone

The inquiry team were informed that residents may make 'phone calls in private.

8.6.7 Arrangements for visitors

There was a small room available for visitors. It was comfortably furnished and in good decorative order. It was outside the locked door to the ward.

8.7 Residents' comments

8.7.1 Eight residents were interviewed. All thought that the ward was clean but nearly all thought it was too warm at times. Most thought the ward was crowded and noisy. Some said they could not easily make private 'phone calls and most felt there were no quiet or private areas. Several residents were unaware of the availability of advocacy. Although most were satisfied with the quality of the food, many felt there was little or no choice.

8.7.2 Some residents had previously had contact with an occupational therapist, social worker or clinical psychologist but there had been little recent contact. Few had received information about their diagnosis and treatment, including possible side effects. Most were unaware of a key worker or named nurse system but most found nurses the best source of help available to them.

8.7.3 Almost all residents felt there were no activities available to them, although one found the hospital occupational department helpful. Only half said they were free to come and go from the ward. Most residents spent their days in the ward and had little to occupy them. Some had been for a drive recently and some went for walks locally.

8.7.4 Half of the residents felt that hospital was not the appropriate place for them but most felt they were safe and nearly all felt they were treated with respect. Half had experienced restraint and all had been searched during their time in hospital. Half had thought about making a complaint about their care and treatment but only half of them felt they knew how to do this. Most of those who had attended a tribunal had received assistance.

8.7.5 One resident complained that the consultant psychiatrist visited the ward once each week but seldom interviewed residents. Another said he was waiting to move to a flat but there seemed to be no progress with this.

8.8 Future plans

8.8.1 The inquiry team was informed that additional day space was to be made available to residents outside the existing ward area.

The residents will be found appropriate alternative accommodation as part of the hospital closure plan.

8.9 Findings

There were no findings specific to St. John's ward.

9. ST. KEVIN'S WARD: 23rd AUGUST 2007

9.1 Description of function and admission criteria

St Kevin's accommodated male residents, most with intellectual disability. There had been no recent transfers or admissions to the unit.

Total Beds	14
Male Beds	14
Female Beds	0
Male residents	14
Female residents	0

9.2 Staffing

9.2.1 Medical

The unit operated under the clinical direction of one of the general adult consultant psychiatrists. There was a NCHD and access to an on-call NCHD. The consultant psychiatrist was not a specialist in intellectual disability. Residents did not have access to a general practitioner.

9.2.2 Nursing

The agreed nursing complement was four during the day and one at night. Nursing staff reported that they were often left with two staff on duty during the day because staff were transferred to other wards. A member of staff was assaulted on the unit a few weeks previously. Staff reported that they had concerns about working on the ward when they were the only member of staff present. Day staff worked either 0800–2030hrs or 0800-1800hrs.

All nursing staff were RPNs and some were also qualified as general nurses. None were trained in intellectual disability nursing. One had a qualification in behaviour therapy. The CNM usually had a 'hands on' role. The ward staffing relied on overtime. A primary and secondary nursing system was used on the unit. There was one household staff allocated to the unit during the day.

9.2.3 Health and social care

A psychologist was contracted to assess residents with an intellectual disability. Assessments, using the Adaptive Behaviour Scale, had commenced three months previously. The psychologist was not a member of the clinical team. There was no psychologist, social worker or occupational therapist attached to the team.

9.3 The residents

9.3.1 On the day of the visit there were 14 residents on the ward. No one was detained under the Mental Health Act 2001; one resident was a Ward of Court. All 14 residents in the ward on the day of the visit had been in hospital for more than twenty years. Four residents were over 65. There were no residents from an ethnic minority and English was the first language of all residents. The primary diagnosis of eight of the residents was intellectual disability and four had a mental illness.

9.3.2 Residents had access to their money. One resident was able to manage his own finances. A small quantity of money was kept in the ward safe and each resident had an individual account. An individual record was kept by the staff of any deposits or withdrawals. The CNM2 made a weekly check on residents' money and there was an annual external audit.

9.4 Care planning

9.4.1 Multidisciplinary team meetings

There was no multidisciplinary team attached to the unit. The consultant psychiatrist and NCHD attended a weekly meeting with nursing staff and attended at other times when requested. The NCHD should have visited daily, but it was reported this did not always happen due to other commitments. An on call doctor was available

9.4.2 Care and supervision

The ward was locked on the day of the visit. It was reported that the door was always locked. There was no policy in place for locking the door. Staff reported that raised levels of observation were not used and that there had been no recent searches.

Ten residents were prescribed diazepam long-term at the time of the visit. Good practice guidance, issued in 2002 by the Department of Health and Children states that the need for long term prescribing should be reviewed regularly and that "the only clinical justification for continuing use is dependence. Planned withdrawal of patients dependent on benzodiazepines should be considered. Attempts should be made to improve levels of mental stimulation and physical activity on long stay wards." It is recommended that long acting, rather than short acting, drugs should be used, if long term prescribing is considered necessary.

9.4.3 Seclusion

There was a seclusion room in the ward. It was reported that the room was no longer used, although it had not been decommissioned. The records of seclusion were kept on St. Bridget's ward and are described in that ward report.

9.4.4 Therapeutic and recreational activities

There were no individualised programmes of activities. It was reported that nurses organised activities when the ward was sufficiently well staffed. There was no occupational therapy available to the residents. Transport was available and trips were arranged, when staffing permitted.

9.4.5 Reviews

There were no individual integrated care plans. Each resident had a nursing care plan, which was reviewed monthly, or weekly if a new problem arose. There was no system for routine psychiatric review of the residents; this was done on a needs basis. Some physical examinations were recorded but these were not carried out six monthly, as required by the Regulations.

9.4.6 Records

There were separate medical and nursing files. Both contained regular progress notes. Recent contact with medical staff was recorded. Medication records were appropriately maintained. There were no personal histories in the casenotes reviewed.

9.5 Advocacy and support

9.5.1 Residents had access to the hospital advocacy service on request. There was a policy to facilitate religious/cultural practices.

9.6 Environment

9.6.1 Sleeping areas and personal space

The sleeping accommodation consisted of a mix of single and shared rooms. There were no curtains around the beds or at the windows. The rooms were bare, with little more than a bed in each. There were no personal effects. There was no personal storage space.

9.6.2 Day areas

There was one large day room that was well furnished. Some residents had their meals in this room because of safety concerns but the majority ate in the dining room. Overall, the ward, while recently decorated, was bare and bleak, particularly the bedroom areas. The use of different colours and textures would have made the environment much more attractive.

9.6.3 Bathroom/toilets

The bathrooms and toilets were in a poor state of repair. Some toilet seats were broken and the toilets were dirty. Staff said the ward cleaner reported sick that morning.

9.6.4 Access to food and drink

There was access to drinking water but hot drinks were only available at set times. There was a set menu. Nursing staff reported that an alternative could be ordered and special dietary needs were met. The resident interviewed was dissatisfied with the quality and choice of food.

9.6.5 Access to outdoor area

There was an outdoor area, which was mainly concreted, and a smoking shelter. One of the residents maintained the garden.

9.6.6 Access to telephone

There was a public telephone available to residents. Nurses reported that residents could also use the ward telephone.

9.6.7 Arrangements for visitors

There was a dedicated visitor's room, which was well furnished.

9.7 Residents' comments

9.7.1 It became apparent to the inquiry team that one resident, who was not detained, was being prevented from leaving the ward. It was documented in his medical file that he consented to this. When interviewed by the inquiry team it was evident that he was not happy with this situation and was not in agreement with it. This concern was reported to the nursing staff.

9.8 Future plans

9.8.1 The future plan for the ward was to merge with St. Bridget's ward, to provide a service for people with intellectual disability. Other residents would transfer to other wards in the hospital or be discharged to community placements. These moves were originally planned for April 2007 and eventually took place at the end of 2007. Nursing staff reported that they were unclear about progress towards merging the wards and about other changes, which was affecting staff morale and was unsettling for residents. However, staff associations were members of the service development group, which was part of the planning structure.

9.9 Finding

9.9 a) The majority of residents received benzodiazepines on a long-term basis, which is usually considered to be undesirable. This seemed, in part, to be a result of a lack of activities and alternative treatment options.

10. ST. MARY'S WARD: 23rd AUGUST 2007

10. 1 Description of function and admission criteria

This was a continuing care ward for men and women that was part of the psychiatry of later life service. About half of the residents were elderly long-stay residents of St. Luke's Hospital and half were elderly people whose mental health needs could not be met outside hospital.

Total Beds	23
Male Beds	11
Female Beds	12
Male patients	10
Female patients	11

10.2 Staffing

10.2.1 Medical

The unit operated under the clinical direction of the consultant in the psychiatry of later life. There was a NCHD and access to an on-call NCHD. There was no general practitioner input.

10.2.2 Nursing

The agreed staffing for the ward was five qualified nurses during the day and two during the evening and night. Day staff worked either 0800 – 2030hrs or 0800-1800hrs. Two nurses were on duty between 1800-2030hrs. The CNM was rostered as part of the daily staff complement. It was reported by staff that significant nursing time was spent on basic housekeeping tasks, reducing the time for personal care of residents.

10.2.3 Health and social care

An occupational therapist provided group work for 1.5 hours on one afternoon a week. There was good access to a speech and language therapist and a dietician from the general hospital but they were not part of the clinical team. There was very limited physiotherapy input. This was identified by staff as adversely affecting patient care. No psychology service was available.

10.3 The residents

10.3.1 Primary diagnoses of residents were mental illness (17), including dementia (seven), and intellectual disability (four). Residents had a wide range of care needs, some required full assistance with all aspects of daily living while others were relatively independent physically.

10.4 Care planning

10.4.1 Multidisciplinary team meetings

Ward senior nursing staff attended the weekly psychiatry of later life team meeting. Other care decisions were made at the weekly ward visit by the consultant psychiatrist.

10.4.2 Care and supervision

Staff reported that the ward was locked at all times. Staff described difficulties in providing adequate supervision and observation between 1800-2030hrs when there were only two staff on duty. There was no written policy on locking the outside door that addressed access by voluntary residents.

A falls risk assessment tool was available and appeared to be in use. Any fall was recorded in the resident's notes and clinical risk forms were sent to the clinical risk manager. There were eight residents with serious mobility problems and many others who were at increased risk of falling. A number of residents used hip protectors. There were policies on the use of bed rails and lap restraints but no overall policy covering restraint and any other limits to freedom of movement.

The inquiry team was told that on recent occasions when residents were receiving terminal care they had been transferred to the local general hospital. The team noted that while staff had knowledge of a pain assessment tool there was no evidence of it being used.

10.4.3 Therapeutic and recreational activities

Nine residents had been assessed by the occupational therapist. At times OT assistants have been employed and activities have been provided in addition to the weekly activity group, which aims to cater for residents' interests. Nursing staff attempted to provide activities within their very limited resources. What was available appeared to be inadequate for the needs of the residents. Ward staff acknowledged that what they could provide was limited and would have liked to do more. Staff reported that the current staffing levels greatly reduced the opportunity to take patients out of the ward for trips or other activities. There were very limited opportunities for holidays away from the hospital.

10.4.4 Reviews

There were no individual multidisciplinary care plans. There was no system of regular multidisciplinary reviews. Each resident had a nursing care plan, which was reviewed by nursing staff every six months, or more often, as necessary. Some physical examinations were recorded but these were not carried out six monthly, as required by the Regulations.

10.4.5 Records

There was evidence of some personal care planning and we were told that a key worker system was in operation. Medication records were appropriately maintained. Personal histories of residents were hard to identify from the records. It was very difficult to establish the personal likes and dislikes and family background of residents.

10.5 Access to advocacy

10.5.1 Residents had access to the hospital advocacy service on request but this was not a dedicated service for older People.

10.6 Environment

10.6.1 Sleeping areas and personal space

The ward had two dormitory areas; eight beds for men and ten beds for women, with five single rooms that were interchangeable. In the dormitories, curtains could be used to screen the beds. The single rooms were small and quite cramped. The male dormitory had banks of lockers along one wall, which added to the institutional appearance. There was very limited evidence of personalisation of sleeping areas. The dormitory areas were situated at both ends of the ward, which had significant implications for care, particularly between 1800-2030hrs, when there were only two nursing staff on duty. There was a locker for each resident. The lockers were not routinely locked. There was very limited storage space for residents, many of whom have been in hospital for many years. The ward was, in effect, their home. The small amount of personal space, even in the single rooms, severely limited opportunities to store personal items, such as toiletries, and to personalise areas with photographs and mementos.

10.6.2 Day areas

There were two main day areas, described as the 'TV room' and the 'sick room'. A large hole in the flooring in the 'TV room' presented a trip hazard. Many of the floor tiles were beginning to lift at the edges and were becoming trip hazards. The day areas were clean and bright. Furniture was adequate in both areas and included a number of specialist chairs for residents. A new smoking room had recently been created. The rooms were unimaginatively decorated and presented an institutional appearance with little in the way of quiet areas for residents away from the bustle of a busy ward. Apart from a TV set there were few focal points, such as chairs arranged round a fireplace, to help provide a domestic scale to the day rooms.

10.6.3 Bathroom/toilets

The shower and toilet areas had tired décor and were in need of refurbishment. There were no toilets adjacent to the dormitories. Residents had to use commodes in the dormitory areas, screened only by curtains. There was a strong odour around the female dormitory area that was unpleasant for residents and undignified for the person using the commode. Although there was one sink in the observation area there were no basins for hand washing, by residents or staff, close to where the commodes were used. The toilet and bathing facilities were described by staff as beingdire.

10.6.4 Access to food and drink

There was a menu system in operation and drinks were provided regularly throughout the day. Some residents described the quality of the food as "fine" but others disagreed. There was little evidence of residents' likes and dislikes being recorded. There appeared to be limited facilities for the storage of favourite foods brought in by relatives.

10.6.5 Access to outdoor area

Although it was possible for residents to sit immediately outside the ward there was no safe garden area, with wide paths and seats, that would have been suitable for residents to spend time walking around in safety.

10.6.6 Access to telephone

A cordless telephone was available for use by residents. There was a public telephone that could be used by residents, with some degree of privacy.

10.6.7 Arrangements for visitors

There was a large and well-decorated room adjacent to the front entrance that provided a pleasant area for residents to see visitors.

10.7 Resident's comments

10.7.1 One resident, who was interviewed, said he felt that he was treated with respect by staff. He said that there was a lack of privacy and very limited availability of activities that were of interest to him.

10.8 Future plans

10.8.1 There were proposals for refurbishment of St. Mary's ward in line with work that had been carried out on a similar medical ward for older people, within the hospital grounds but the inquiry team was informed later that replacement of the unit was more likely.

10.9 Findings

10.9 a) 23 residents, with widely varying needs, were cared for in areas at each end of the ward. During the evening and at night there were only two members of nursing staff and it was not possible for them to supervise and provide personalised care to all the residents.

10.9 b) There was insufficient availability of basins for hand washing following the use of commodes.

10.9 c) Although seven of the residents had dementia, there was little evidence of 'dementia friendly' design features, such as appropriate signage for toilets.

11. ST. PAUL'S WARD: 24th AUGUST 2007

11.1 Description of function and admission criteria

The unit provided high support continuing care for older men. There were no specific admission, transfer or discharge policies for the unit

Total Beds	22
Male Beds	22
Female Beds	0
Male residents	21
Female residents	0

11.2 Staffing

11.2.1 Medical

The unit operated under the clinical direction of one of the general adult consultant psychiatrists. There was a NCHD and access to an on-call NCHD. There was no general practitioner input.

11.2.2 Nursing

The agreed staffing levels for the unit were a minimum of five nurses during the day and two at night (2030-0800hrs). Staff reported that often only four nurses were on duty. Day staff worked either 0800-2030hrs or 0800-1800hrs. Two nurses were on duty between 1800-0800hrs. The CNM usually had a 'hands on' role and, frequently, a student nurse was rostered. Staffing of the unit at the agreed level depended on overtime working. On the day of the visit nursing staff were putting away laundry and they reported that this and other non-nursing duties, such as organising

the evening meal, took up a lot of their time. Some staff had trained in behaviour therapy or psychosocial interventions but stated that they did not have opportunities to put their skills into practice.

11.2.3 Health and social care

No health and social care professionals were members of the clinical team. Referral could be made for physiotherapy or to social work. There was access to a CNS in wound care and to a community occupational therapist for seating assessments, if required.

11.3 The residents

11.3.1 Fifteen residents had a diagnosis of mental illness and seven had intellectual disability. Many of the residents had high levels of dependency. Two residents were wards of court. The ages of residents ranged from 49 years to 88 years. Most residents were over 65 years. The length of stay in hospital ranged from two to over 12 years. Eight of the residents were from North Tipperary. Two thirds of the residents had access to their own money and used it for purchasing goods through an ordering system, as there were no shops nearby. Staff expressed concerns about the cost of items and the lack of opportunity for participation, by residents, in the process of purchasing items, as these had to be ordered in advance through the nurses. Residents' accounts were audited annually by the hospital auditor.

11.4 Care planning

11.4.1 Multidisciplinary team meetings

There was no multidisciplinary team. The consultant psychiatrist and NCHD met with nursing staff each week to review the residents' care.

11.4.2 Care and supervision

The unit was locked on the day of the visit and staff reported it was always locked for the safety of a few residents who were at risk of wandering. This intervention was not documented as part of any resident's care plan and there was no policy on locking the door. Staff reported that seclusion or raised levels of observation were not used and that searches were not carried out.

Residents interviewed confirmed this. There were no information leaflets for residents or relatives.

11.4.4 Therapeutic and recreational activities

There were no individual programmes of activities provided on the unit and residents did not attend activities off the unit. There were recreational group activities provided on the unit but no therapeutic activities, linked to a care plan. There was access to a minibus or taxi service but staff reported that residents had to be accompanied, because of high dependency needs, and usually there were insufficient staff to supervise day trips. None of the residents had a holiday in the past year.

11.4.5 Reviews

There were no individual integrated care plans. Each resident had a nursing care plan, which focussed on ongoing care. The nursing care plan was reviewed by nursing staff every six months, or more often if a new issue arose. Psychiatric review of the residents was done on a needs basis or at the time of physical examinations. Approximately annual physical examinations were recorded. Regulations require six monthly examinations.

11.4.6 Records

There were separate medical and nursing files. There were regular progress notes in both. Recent contact with medical staff was recorded. Medication records were appropriately maintained. There was no recent accessible personal history in several of the clinical files reviewed by the inquiry team.

11.5 Advocacy and support

11.5.1 Residents had access to the hospital advocacy service on request. There was no befriending scheme. There was an HSE South policy on religious/cultural practices.

11.6 Environment

11.6.1 Sleeping areas and personal space

There were two dormitories with ten and eight beds respectively. One dormitory was located near the nurses' station. The other was located at the other end of the unit, which gave rise to difficulties in observing all the residents, particularly from 1800-0800hrs when there were only two staff on duty. One resident told us that he had to go to bed at 4.30pm and often would like to stay up later. Staff informed the inquiry team that there were insufficient staff to manage his challenging behaviour. A number of residents went to bed very early.

There were four single rooms, which were dark and stuffy and some had no curtains. These rooms were too small for the wardrobe doors to open, so the doors had been removed. The floors and floor coverings in some of the single rooms were uneven and broken in places, creating a trip hazard. The dormitory areas had been painted recently and had new floors. Although new wardrobes had been delivered for the dormitory areas there was not yet one for each resident. Staff reported that replacement wardrobes had first been requested three or four years ago. There were three areas on the unit, including the bathrooms, where clothes were stored, as there was not sufficient wardrobe space.

11.6.2 Day areas

The sitting area had been repainted and there were new sofas. The floor and floor covering in the dining room was uneven and broken in places, creating a trip hazard. The ward was very warm and there was no local control of the heating system.

11.6.3 Bathroom/toilets

There was one bathroom for 22 residents, with a shower and a bath. This was not sufficient and resulted in residents having to share the bathroom and use screens for privacy. There was no ventilation in the bathroom and the paint on the walls was peeling, as a result of a leak in the roof. There were separate toilets.

11.6.4 Access to food and drink

Bottled water was available and there were water dispensers in the unit. Residents were not allowed to make hot drinks or snacks for themselves.

11.6.5 Access to outdoor area

There was no safe outdoor space. There was a building site beside the ward, making it noisy, unpleasant and dusty to sit outside. The ward was at the top of a steep incline, making it difficult for elderly residents to walk about outside.

11.6.6 Access to telephone

The public phone was out of order. Residents had access to the ward cordless telephone, which was more private, as it could be used anywhere.

11.6.7 Arrangements for visitors

Visiting times were flexible. There was a visitors' room at the entrance to the unit. It was small and dark and could only accommodate one group of visitors. Other visitors used the corridor. There were no toilet facilities nearby.

11.7 Residents' comments

11.7.1 Two residents commented on a lack of personal space and lack of access to an outside area. One resident reported that his bedroom was stuffy.

11.8 Future plans

11.8.1 The plan was for the ward to close eventually and this was dependent on all residents being assessed and suitable placements identified for them. A psychologist was due to commence the assessment of residents with intellectual disability in September 2007. The assessments would inform future service development, following consultation with service providers. One resident had been assessed and was awaiting placement in Cashel.

11.8.2 Subsequently, the inquiry team was informed that it was likely that residents of St. Paul's ward would be transferred to St. Clare's ward, allowing closure of St. Paul's ward at an earlier date.

11.9 Findings

11.9 a) One resident was obliged to go to bed at 4.30pm because there were insufficient nurses to supervise him.

11.9 b) Residents did not have easy access to some of their possessions, which were stored communally. This was a result of shortage of storage space in dormitories and bedrooms.

11.9 c) It was difficult for the elderly residents to get out and about because of the distance to local shops and facilities and because of difficulty in providing escorts.

11.9 d) The area for visiting was inadequate and visits took place in the corridor at times.

12. ST. TERESA'S WARD: 22nd AUGUST 2007

12.1 Description of function and admission criteria

This was the designated rehabilitation ward. Residents were transferred there from long-stay wards with the aim of preparing them for more independent living. Referrals from the admission unit were also accepted. Admission to the ward was by referral to the rehabilitation team.

Total Beds	22
Male Beds	10
Female Beds	12
Male residents	10
Female residents	11

12.2 Staffing

12.2.1Medical

The consultant psychiatrist had a half-time commitment to rehabilitation. A NCHD provided day to day medical advice to the ward and visited on most days. There was no general practitioner service to residents.

12.2.2 Nursing

There was a record of the staff on duty and in charge. Three registered nurses were on duty at the time of the visit, which was the agreed staffing level, but we were told that staff were often taken from the ward to cover shortages elsewhere. At night the agreed staffing was one nurse.

12.2.3 Health and social care

An occupational therapist had recently taken up post in the ward and a programme of activities was being developed. A clinical psychologist (0.2wte) attended team meetings and worked with three residents. Referral could be made for social work involvement.

12.3 The residents

12.3.1 No residents were detained. Two residents were wards of court. All 21 residents had a primary diagnosis of mental illness. Seven residents were aged 27-44, 13 were 45-64 and one was over 65. Four residents had been in hospital for less than two years, ten for two to five years, five for five to ten years and one for over ten years. English was the first language of all residents and none were from an ethnic minority group.

12.3.2 All residents, apart from the wards of court, could access their money and could spend it as they wished. 14 residents managed their finances, including cashing benefit cheques and paying the hospital for care costs. Relatives managed the finances of one ward of court, who had a budgeting programme. There was an annual audit of the ward financial management.

12.4 Care planning

12.4.1 Multidisciplinary team meetings

A weekly meeting was attended by the consultant psychiatrist, NCHD, nursing staff, occupational therapist and clinical psychologist. Day to day problems were discussed. A programme of regular reviews had been introduced.

12.4.2 Care and supervision

No residents were on raised levels of observation at the time of the visit. There was a written policy for searches. Occasional searches of property were recorded. The ward door was never locked. The medication prescribed for residents appeared to be appropriate, from a brief inspection of the medication records.

12.4.3 Seclusion

Seclusion was not used.

12.4.4 Therapeutic and recreational activities

An occupational therapist had recently begun working with residents but individualised activity programmes were not yet developed. An activity programme was organised by nursing staff. Some residents took part in activities outside the ward. Two attended Cluain training centre in Clonmel. Others attended the hospital occupational department. The activities there were mainly recreational or work orientated. It was reported that payment for attendance at the department was a disincentive to attending ward-based occupational therapy Group training in life skills had been attempted at one time but was being replaced by individualised programmes.

Transport was usually available for outings. Holidays were organised for residents during the previous year.

12.4.5 Reviews

Residents were encouraged to attend review meetings. Relatives and social work staff were invited to attend. Some physical examinations were recorded. These were scheduled annually, rather than six monthly, as required by the Regulations.

12.4.6 Records

All residents had individual nursing care plans, which were reviewed every three to six months. The care plans were mostly two or three years old, not very detailed or specific (e.g. ‘stabilise mental state’). Personal histories of residents were often very brief and buried in old volumes of notes, although a number of up to date summaries had been completed by the time of the second

visit in October. There were regular progress notes in both the nursing and medical notes. Recent contact with medical staff was recorded. Medication records were appropriately maintained.

12.5 Advocacy and support

12.5.1 Residents could access the hospital advocacy service on request and the recently introduced befriending scheme. The ward had a written policy to facilitate religious and cultural practices. An information leaflet was available for residents and relatives.

12.6 Environment

12.6.1 Sleeping areas and personal space

The men had single bedrooms. They had door keys. These rooms were small and quite bare, with few personal possessions apparent. The women slept in dormitories, two or three to a room. Two dormitories lacked bed screens and one had a non-functioning CCTV camera, a relic from when the room was used for interviews. These rooms were also bare. There were lockable wardrobes. 'Personal space' in the dormitories was limited to the area enclosed by bed screens – where these were provided. Residents could have access to bedrooms during the day but were encouraged to be active. All the bedrooms were in a fairly poor decorative state. Household staff cleaned the rooms regularly and some residents assisted. The female dormitories were on the floor above the male bedrooms. The corridor outside the female dormitories was in poor condition and appeared to be affected by water penetration.

12.6.2 Day areas

There were several sitting areas, with plenty of space for residents. The dining room was also spacious. These day areas were in good decorative order and there were colourful prints on the walls. Some areas of the ward were well maintained but others needed redecoration and some of the corridors were in a poor decorative state, with peeling wallpaper and paint.

12.6.3 Bathroom/toilets

There was one bathroom and there were two showers for 21 residents. These were generally clean, although some of the floors were wet at the time of the visit. One bath was designed for

the physically disabled and this was inappropriate in this ward. There were urinals in the female toilet area. Staff said that a request for their removal was first made two years earlier. Ceiling tiles had been missing from another toilet for a similar time. There was adequate privacy in the toilets and bathrooms.

12.6.4 Access to food and drink

There was unrestricted access to drinking water. There was a well-equipped training kitchen but this was not available to residents outwith training sessions. Hot drinks were only available at set times. There was no provision for residents to make snacks.

12.6.5 Access to outdoor area

There was a large outdoor area that was mainly surfaced with concrete but there was a grassed area. Access was easy, as all residents could leave the ward without restrictions.

12.6.6 Access to telephone

The inquiry team were informed that residents may make telephone calls in private.

12.6.7 Arrangements for visitors

Several day areas were available for visits.

12.7 Residents' comments

12.7.1 Six residents were interviewed. They had some concerns about the ward environment but the majority were content with it. Some felt they could not easily make private telephone calls. Opinions about the food varied. Several residents felt there was little or no choice and the quality was poor.

12.7.2 All the residents interviewed said they had contact with an occupational therapist and a psychiatrist but none had contact with a psychologist or social worker. Most had received some information about their diagnosis and treatment, including possible side effects. Half were

unaware of a key worker or named nurse system but most found nurses the best source of help available to them.

12.7.3 Activities were available to all and they were generally found helpful but not chosen individually. All residents could come and go from the ward without restriction. Most residents spent their days at the hospital occupational department or in the ward.

12.7.4 Most but not all residents felt that hospital was the appropriate place for them and all felt safe and felt they were treated with respect. Some had experienced restraint and searching but not while in St. Teresa's ward. No one wanted to make a complaint about their care but all knew how to do this.

12.7.5 One resident complained about being excluded from his room during the day. Another complimented the kitchen staff but was concerned about hygiene in the ward and the poor physical environment, complaining that curtains were falling down and the roof was leaking.

12.8 Future plans

12.8.1 Eight residents were waiting to move to hostel accommodation in Cashel, which will have a rehabilitative role. Several members of staff were due to accompany them. It was anticipated that, in time, the remaining residents would move to supported accommodation locally. The hostel opened at the end of 2007.

12.9 Findings

12.9 a) A multidisciplinary rehabilitation team was being formed but effective individual care planning was not in place at the time of the inquiry team visit.

12.9 b) The day rooms of this ward had been attractively refurbished, in contrast to other parts of the ward and to other wards.

13. ST LUKE'S HOSPITAL

13.1 Comment

13.1.1 One of the features of institutionalisation is that the priorities of those running the institution take precedence over those of the residents. Shortage of resources, including staff, makes this almost inevitable, as cost is seen as being more important than choice. *A Vision for Change* makes clear that services should be designed to meet the practical needs of service users, who should be active participants in their recovery, rather than passive recipients of 'expert' care. The description of the care of residents of St. Luke's Hospital matches that of an institutional model rather than the model of *A Vision for Change.*

13.1.2 The result of this was that residents' choices, freedoms and opportunities were restricted more than was necessary for the care and treatment of their condition and their lives were impoverished. This was made worse by a living environment that was bare and functional and not designed to be a home. After years of living in the hospital residents appeared to have little sense of identification with, or ownership of, their environment, as demonstrated by the scarcity of personal effects in sleeping areas.

13.1.3 Although very few residents were detained under the Mental Health Act 2001 several ward doors were locked and staff referred to residents being 'allowed out' or given 'parole', when they should have been free to come and go as they wished. Another major area of restriction was the shortage of appropriate activities to take part in, particularly activities that took place outside the hospital and would assist a process of recovery and social integration.

13.1.4 Residents would require support, through an advocacy process, to participate actively in their care but this would only succeed if professional staff were receptive to the change and this would require staff training and preparation.

13.2 Findings

13.2 a) The wards, including bedrooms, were generally painted in a single colour, giving a monotonous and institutional appearance to what was, in effect, the resident's home.

13.2 b) Most dormitories and bedrooms appeared bleak, some even lacked curtains, and there was little personal space for residents.

13.2 c) The day rooms generally had an institutional appearance, although refurbishment of these areas in St. Teresa's ward demonstrated that this problem could be overcome.

13.2 d) Some wards had training kitchens but these were not usually available to residents for general use. This arrangement was not based on a system of individual risk assessment and may not always have been necessary.

13.2 e) Several wards had only one bathroom and the bathrooms and toilets generally appeared institutional in design and decoration.

13.2 f) Many of the enclosed external areas were unattractive. Most of the areas contained a few neglected plants and were surfaced with concrete.

13.2 g) Residents were put at risk by some ward layouts, which made observation and care difficult, and by damaged flooring and other defects. Long delays in completing repairs and maintenance compounded these problems.

13.2 h) Most wards were locked and it appeared that this was not always necessary but there was no system of review. The freedom of movement of most residents, who were not detained, was unnecessarily restricted.

13.2 i) Many residents found it difficult to find a quiet place. Many felt their ward was noisy.

13.2 j) Competing clinical commitments reduced the availability of consultant psychiatrists and compromised their ability to provide clinical leadership.

13.2 k) Residents' medical care, including annual physical examinations, was provided by hospital staff. Residents did not hold medical cards and did not have access to primary care services.

13.2 l) On most wards, doctors and nurses met regularly and addressed day to day clinical matters but a programme of regular psychiatric review was often not in place.

13.2 m) Many residents appeared to have little knowledge about their diagnosis, treatment and side effects and this would impair their capacity to give informed consent to treatment.

13.2 n) There was very little involvement of health and social care staff and so there were, effectively, no multidisciplinary needs assessments or individual care plans.

13.2 o) Clinical records generally contained little personal information about residents' backgrounds to inform needs assessments and the provision of person centred care.

13.2 p) Few activities were based on individual assessments or were designed to facilitate discharge, although this approach was being developed in St. Teresa's ward.

13.2 q) Residents were not often asked about their preferences for activities or offered alternatives.

13.2 r) Some residents attended the occupational unit but there was little to occupy most residents other than some activities and outings that were organised by ward staff.

13.2 s) Overtime working was often necessary to achieve agreed nurse staffing levels.

13.2 t) There was a serious shortage of trained nurses and unexpected absences led to nurses being transferred from one ward to another, at short notice, reducing staffing levels and disrupting the care of residents.

13.2 u) Nursing time was taken up by tasks, such as laundry and catering, which could have been done by others. This, together with staffing shortages, limited the ability of nurses to provide personal care to residents, or to organise activities.

13.2 v) The interventions specified in nursing care plans were not based on comprehensive needs' assessments. Many residents did not understand the keyworker system.

13.2 w) The residents of individual wards often had disparate needs and vulnerable residents were, at times, at risk from the behaviour of others.

13.2 x) At the time of the inquiry team visit residents with intellectual disability did not have dedicated accommodation, although this has long been considered to be essential, and there were no staff with qualifications in intellectual disability care.

14. RESIDENTS' VIEWS AND EXPERIENCES

14.1. This section summarises the views and experiences of the residents of St. Michael's Unit and St. Luke's Hospital who spoke to the inquiry team and describes some of the findings of a recent survey of residents' views on the activities available in St. Michael's Unit.

14.2 Residents who spoke to the inquiry team

14.2.1 The inquiry team interviewed 31 residents. Their views and experiences were recorded (apps.3&8) and they provided an insight into residents' experience of hospital life and the care they received. The inquiry team interviewed all the residents who said they were willing to be seen. Their views are summarised below.

14.2.2 Some of the responses confirmed information already available from other sources; the limited of contact with health and social care professional staff and the lack of activities, particularly those aimed at benefiting the individual's mental health.

14.2.3 Residents generally felt the wards were clean and airy but some felt there was inadequate separation of smoking and non-smoking areas and found the wards stuffy. Most residents thought the wards were noisy and some found them crowded. Many had difficulty in finding private space, particularly in St. Michael's Unit. Although drinking water was readily available for most residents, hardly any were allowed to make a hot drink for themselves. Over a third of those interviewed felt the food was not of good quality and felt there was no real choice at mealtimes.

14.2.4 Information available to residents was variable. Most residents knew the name of their consultant psychiatrist but many long-stay residents appeared to have little information about their diagnosis or medication. Two thirds of the residents were unaware of the named nurse/keyworker system, suggesting that it was not working effectively. However, most residents felt nurses were the people who were most helpful to them.

14.2.5 Activities were available to only one in three of the residents and the activities were not generally considered to be likely to assist recovery. Only one in four residents recalled being asked what they would like to do.

14.2.6 A minority of residents recalled being informed about individual rights or advocacy and few had received any written information about their ward. Freedom of movement was often

restricted. Searching and removal of access to day clothing appeared to occur frequently in St. Michael's Unit. Despite this, almost all residents felt they were treated with respect, most felt they were safe and about half agreed that they should be in hospital.

14.2.7 Almost half of those interviewed had, at some point, wanted to complain about the care they had received.

14.3 Activities in St. Michael's Unit

14.3.1 Social work staff carried out a survey of the views of service users on recreational and therapeutic activities. 30 residents were interviewed during April and May 2006. A programme of activities was available to residents. Sessions were available most mornings and some afternoons. These were provided by nursing staff and by organisations, such as advocacy, GROW, A.A. and Schizophrenia Ireland. Individual sessions were usually attended by about ten residents. Residents were able to take part in other activities, such as painting, social interaction, reading newspapers, playing cards or board games and walking or exercising.

14.3.2 One in four residents thought the variety and availability of activities was good or very good but half the residents felt there was a lack of activities. More than a third of residents felt none of the activities available were relevant or useful to them. Most residents felt there was inadequate space for activities. The activity that most residents missed was the opportunity to exercise or take part in sport.

14.4 Comment

14.4.1 It is important to give residents an opportunity to express their views on the provision and development of services and to provide any necessary assistance to enable them to do this.

14.4.2 When the inquiry team visited St. Luke's Hospital and St. Michael's Unit there was no residents' association or group that could be consulted, in order to obtain a shared view of residents' lives and experiences. The team consulted the advocacy worker and met 31 residents. The team considered their views to be the best available information on this subject.

14.4.3 Some opinions, expressed by residents, are contained in this report. These opinions appeared to the inquiry team to be genuinely held, rather than manifestations of mental illness or

intellectual disability. Relevant information from other sources is provided, where this was available.

14.5 Finding

14.5 a) While many residents made positive comments about their care, almost half of the residents, who were interviewed by the inquiry team, had considered complaining about their care at some time during their hospital stay.

15. ADMISSION AND DISCHARGE

15.1. This section describes factors that contribute to a high occupancy level in St. Michael's Unit, with adverse consequences for residents, and the problems that will have to be addressed in order to develop a service that does not depend too heavily on admission to hospital for the provision of care and treatment.

15.2 Admission

15.2.1 A revised South Tipperary mental health services policy on access, assessment, admission and discharge was introduced on 26th June 2007. The policy stated that general practitioners should make all referrals to the sector community outpatient service for assessment. New referrals of those over the age of 65 should be made to the psychiatry of later life team. The policy stated, "Following assessment, patients/residents are admitted in accordance with the Mental Health Act 2001. All admissions must be in line with the Referral and Admission policy."

15.2.2 Despite the policy of referral to community teams, which should include consideration of alternatives to admission, almost 70 per cent of admissions in 2006 took place out of hours and bypassed the preferred assessment arrangements. Over half of these admissions occurred before 22.30. Out of hours the on-call NCHD was responsible for the assessment, in St. Michael's Unit, of those who presented at the Unit or at the general hospital, where the facilities for interview were unsatisfactory. The NCHD was required to consult the on-call consultant psychiatrist, following the assessment. Some members of staff in St. Michael's Unit considered the threshold for admissions to be low. Members of staff informed the inquiry team that local people were aware that it was easier to gain admission by presenting to the Unit out of hours than during the day. Some members of staff expressed the view that the current arrangement did not prevent non-urgent admissions out of hours and that this was because a consultant psychiatrist was not directly involved in making assessments at these times. They believed that other acute units in the region were more successful in limiting such admissions. The consultant psychiatrists stated that difficult clinical decisions about admissions, especially late at night, had to be taken, which reflected the real risks, particularly in the absence of alternative supports both within mental health services and without. They believed it was better to err on the side of safety.

15.2.3 In 2006 an 'Alternatives to Acute Inpatient Care Survey' was carried out. 328 admissions, which took place over a six month period, were included in the survey. In the opinion of the responsible consultant psychiatrists, a crisis house may have been useful in 20 per cent of cases and, in 23 per cent of cases, availability of a 'step down facility' may have led to

early discharge. 18 per cent of admissions were considered unnecessary. It seems likely that there was overlap between the groups. Information was not available in a significant percentage of cases, indicating that there was significant potential to reduce and shorten admissions.

15.2.4 In 2005 there were 764 admissions to the Unit, 198 of which were first admissions. In 2006 there were 668 admissions. 175 of these were first admissions. In 2005 there were 129 admissions to St. Luke's Hospital and 100 in 2006. Total admissions from Tipperary were, therefore, 893 in 2005 and 768 in 2006. Only one per cent of admissions were of people from outside Tipperary. In 2004 the average admission rate in Ireland was 569 per 100,00 population, 157 of these being first admissions, according to *A Vision for Change*. This would equate to 848 admissions, including 234 first admissions for a population of 149,000, equivalent to North and South Tipperary. The admission rate in Tipperary is, therefore, near the average for Ireland.

15.2.5 The inquiry team was informed that St. Michael's Unit was almost always full and there was usually a list of patients awaiting admission. Assuming 100 per cent occupancy of the 49 beds, the 764 admissions to St. Michael's Unit in 2005 would have had an average length of stay of 23 days. The 668 admissions in 2006 would have had a length of stay of 27 days. The reduction in the number of admissions between 2005 and 2006 did not lead to a reduction in the occupancy level. The increase in the length of stay may well have prevented admissions by reducing the availability of beds. The admission rate to St. Michael's Unit did not change significantly in the first six months of 2007.

15.2.6 The high occupancy level of St. Michael's Unit caused several problems. The Unit was overcrowded, no beds were available for those requiring admission, the beds of residents on leave were occupied by others and even one of the seclusion rooms was in use, as a bedroom, at the time of the inquiry team visit. These factors, together with others, identified in section 5 of this report, would be expected to have a negative effect on residents and staff. This would be likely to lessen the effectiveness of treatment and contribute to slower recovery. A shortage of professional staff would have a similar effect and nursing staff told the inquiry team that they considered the number of nurses in the ward was inadequate, both during the day and at night. In addition, there was an absence of occupational therapists and a shortage of other professions in some teams.

15.2.7 In the past, admissions to St. Luke's Hospital relieved the pressure on St. Michael's Unit but this is against national policy and has been severely criticised in the Inspector of Mental Health Services annual reports. The local admission policy now states, "There should be no admissions to St. Luke's Hospital with the exception of respite beds in St. Mary's Ward and

rehabilitation beds in St. Teresa's Ward." There were nine admissions to the hospital in the first six months of 2007. Since then there has been one admission to a continuing care ward.

15.2.8 Several teams admitted patients to St. Michael's Unit. There were three adult teams in South Tipperary and two in North Tipperary. North Tipperary is part of HSE West but there is no provision for admission there. The psychiatry of later life team admitted a small number of patients and the rehabilitation team and the child and adolescent psychiatry team occasionally admitted patients. Simply providing enough rooms for the team members was a major problem. The development of policies to reduce the number, or shorten the length of admissions would be very difficult because of the number of teams. The population of North Tipperary accounts for 44 per cent of the population of Tipperary but only 29 per cent of admissions to St. Michael's Unit during the first six months of 2007. In 2006 it was 35 per cent. The reason for the variance between North and South Tipperary was unclear. Access may have played a part but the recent change in North Tipperary arrangements, where a single consultant psychiatrist was responsible for the care of all residents, would be unlikely to influence the admission rate.

15.2.9 A reduction in the number of teams admitting patients to St. Michael's Unit would be desirable. The continuation of the admission of North Tipperary residents makes it more difficult to resolve the problem of high occupancy. However, local agreement to admit North Tipperary residents to beds within HSE West was only reached in September 2007 and planning is in its infancy.

15.3 Discharge

15.3.1 The policy that was introduced in June 2007 set out arrangements that complied with legal requirements and good practice guidance. The policy outlined procedures aimed at the avoidance of homelessness following discharge. The inquiry team was provided with samples of discharge letters that were in keeping with these aims.

15.3.2 The inquiry team was informed that there were sometimes problems in finding suitable placements for residents who were ready for discharge. This added to the resident's length of stay in hospital and may have contributed to the problem of high occupancy outlined above. The size of this problem was unclear. A pilot project was being undertaken, at the time of the inquiry team's visit, in which two nurses were employed, to assess whether improved community services would reduce the need for admission or reduce the length of stay in hospital. The outcome of the pilot home based project is being assessed externally.

15.3.3 The availability of community based services affects both the need for admission and the timing of discharge. At the time of the inquiry team visit there were no occupational therapists in the community teams and few community nurses. One team had no clinical psychologist. There were day centre and day hospital places and a substantial number of supported residential placements, although these may not have been readily available to recently discharged residents. The staffing of the community teams was substantially lower than was recommended in *A Vision for Change*. Several members of staff expressed the opinion that the problem of high occupancy of St. Michael's Unit would be solved by the provision of improved community services

15.4 Comment

15.4.1 The imbalance between the number of admissions and the number of beds is clearly unsatisfactory. However, a service based on the recommendations of *A Vision for Change* would have fewer admission beds. In Tipperary there would be around 25 beds, of which around 18 would be for adults with mental illness. Fewer and shorter admissions would be required.

15.4.2 The 2006 local survey of admissions suggested that there was substantial scope for a reduction in admissions, although the inquiry team was not made aware of any developments following on from this survey. The local five year plan envisaged beginning to reduce admission bed numbers in 2008. Over two thirds of admissions take place out of hours, half of them before 22.30. The availability of an experienced psychiatrist, to personally supervise or carry out assessments in the evening would merit consideration. Similarly, examination by an experienced psychiatrist of all admissions within 24 hours of admission, including at weekends, would allow early discharge of people admitted unnecessarily. Both these options, if implemented, should result in a reduced need for admission beds. In time the rehabilitation service is likely to develop a focus on residents who are resistant to treatment or difficult to discharge, which should result in earlier transfer from the admission unit but the St. Luke's Hospital closure project is likely to be a greater priority for the service for some time. A focus on more efficient bed use would also be likely to result from greater availability of relevant statistical information.

15.4.3 Services operating with lower bed numbers will inevitably continue to admit the most unwell. Immediate risk of harm to self or others, often accompanied by psychosis, will be the likely reasons for admission. This will change the environment of the admission unit and will require a change in expectations by staff and by people in the community. An example of this is that, at the time of the inquiry team visit, 29 residents of St. Michael's Unit were considered to need nursing, in hospital, in nightclothes. Under *A Vision for Change* service model, almost half of them would be treated in the community. The development of additional community services may reduce the need for admissions but not all studies have found this. Closer monitoring may

lead to an increased pressure for admission. It may be helpful for key members of clinical staff to visit services with a model similar to that described in *A Vision for Change*, in order to become more familiar with this approach.

15.4.4 It was difficult for clinical staff based in St. Michael's Unit to develop a team approach when working with up to eight sector and specialist teams. This should be eased by a reduction of South Tipperary sectors to two and, presumably, by the eventual reprovision of the North Tipperary service. In the future, however, this benefit may be lost, as the admission service may need to be delivered on a regional basis in view of the reduced number of beds. Development of a specialist admission team may merit consideration. This would impair continuity of care but may be more efficient, by reducing travelling time, for example.

15.4.5 The Report of the Inspector of Mental Health Services 2007 commented, *"The continued admission of people to St Luke's Hospital was of concern, although it was at a lower rate than reported in 2006."*

15.5 Findings

15.5 a) The number of referrals for admission to St. Michael's Unit often exceeded its capacity.

15.5 b). Most admissions took place in the evening or at night and were not screened as fully as daytime admissions.

15.5 c) The existence of a waiting list indicated that there was a potential for more admissions but raised a question about the urgency and need for admission.

15.5 d) The management of St. Michael's Unit was complicated because up to eight sector and specialist teams, including two from North Tipperary (HSE West), admitted people there.

15.5 e) *A Vision for Change* recommended a substantial reduction in hospital care. A local survey, in 2006, identified possible ways to achieve this but these have not been developed further.

15.5 f) The admission rate for Tipperary was near the average for Ireland. Rural areas usually have below average admission rates but areas of deprivation may offset this.

15.5 g) Admissions to long-stay beds in St. Luke's Hospital had virtually ceased. Any admissions are contrary to hospital and national policy.

16. CARE PLANNING

16.1. This section describes the legal requirements and good practice guidance on care planning and current care planning arrangements in South Tipperary. Proposals for future developments within the service are outlined.

16.2 Legal requirements and good practice

16.2.1 The Mental Health Act 2001 (Approved Centres) Regulations 2006 (S.I. No. 551 of 2006), states, "*The registered proprietor shall ensure that each resident has an individual care plan."* For the purposes of the Regulations the registered proprietor for each approved centre was the Local Health Manager at the time of the inquiry.

16.2.2 The Regulations define an individual care plan as follows. *"Individual care plan means a documented set of goals developed, regularly reviewed and updated by the resident's multi-disciplinary team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident. For a resident who is a child, his or her individual care plan shall include education requirements. The individual care plan shall be recorded in the one composite set of documentation."*

16.2.3 The national mental health policy, *A Vision for Change*, defines what residents can expect from their care plan. Recommendation 3.1 states, *"Service users and carers should participate at all levels of the mental health system."* Later it is stated, *"The most immediate way that a service user or carer can be involved in mental health care is through the development of their own care plan, in conjunction with a multidisciplinary team.*

16.2.4 In Chapter 9 the process of setting up a care plan is outlined; *"The needs of each service user should be discussed jointly by the team, in consultation with users and carers, in order to construct a comprehensive care plan. Care plans should be written and agreed between all parties, and include a time frame, goals and aims of the user, the strategies and resources to achieve these outcomes, and clear criteria for assessing outcome and user satisfaction."*

16.2.5 The Mental Health Commission's *"Quality Framework-Mental Health Services in Ireland"*, published in March 2007, outlines in Theme 1, Standard 1.1, *"Each service user has an individual care and treatment plan that describes the levels of support and treatment required*

in line with his/her needs and is co-ordinated by a designated member of the multidisciplinary team, i.e. a key-worker." The Commission proposed that services should begin to implement this standard during 2007. A realistic timeframe for full compliance should have been set during the year. The standard is comprehensive and includes a requirement for a composite set of documentation, care provision on a multidisciplinary basis, individual needs assessment and service user involvement.

16.2.6 In the *Report of the Inspector of Mental Health Services 2006* it was stated that, in South Tipperary, *"integrated care planning and multidisciplinary care plans have not begun although a commitment to do so was expressed by the senior management team."*

16.2.7 In making an assessment of local care planning the inquiry team studied documents provided by the senior management team and interviewed members of staff. Residents were interviewed and medical and nursing notes were reviewed during visits to the wards.

16.3 St. Michael's Unit

16.3.1 There were separate medical and nursing files. There were no individual multidisciplinary care plans. Each sector team in St. Michael's Unit held a weekly meeting at which the resident's mental state and progress were reviewed. On the male side of the Unit it was reported that all members of the multidisciplinary team attended, while on the female side it was reported that the nursing, medical and social work staff attended on a regular basis and other professional staff attended when they were able. Residents attended the meetings and relatives were invited to attend.

16.3.2 Each resident had a nursing care plan. There was evidence of regular reviews, which were carried out by the resident's primary nurse. However, the recorded planned interventions did not describe how specific needs were to be addressed or goals achieved. As noted earlier, half the residents interviewed by the inquiry team were unaware of the named nurse system.

16.3.3 A care plan audit was carried out in the Tipperary sector on the 18th and 19th July 2007. Non-conformance with the standards varied between 15 per cent and 50 per cent and averaged 30 per cent but it was concluded that the document was being accurately used. A number of comments were made: the care plans and evaluations needed to be updated more regularly, there was no place for clients to sign the document and, at times, there was no evidence of primary nurse allocation.

16.3.4 Nursing staff reported that there was a policy that all residents should have an annual physical review. Regulation 19 states that each resident must have a physical review at least every six months. The inquiry team reviewed the medical files of residents who had been in the Unit for over a year and these confirmed that 6 monthly physical reviews were not carried out.

16.4 St. Luke's Hospital

16.4.1 There were separate medical and nursing files. There were no individual multidisciplinary care plans. Each resident had a nursing care plan. Over two thirds of the residents interviewed by the inquiry team were unaware of a named nurse system. Medical files usually contained a record of an annual physical review and a record of other physical problems. Psychiatric reviews were generally carried out on an 'as required' basis, rather than being regular and systematic. Records of reviews of mental states seemed infrequent and this has been commented on by clinical risk managers.

16.4.2 Each of the sector consultant psychiatrists had clinical responsibility for one of the continuing care wards (St. Kevin's, St. John's, St. Bridget's, St. Paul's and St. Clare's). A NCHD usually visited each ward every day. Health and social care professional staff from the sector teams were not usually involved in the care of long-stay residents and there was no dedicated sessional allocation. The consultant psychiatrist visited the wards on a weekly basis and reviewed the care of residents. Nursing staff in one ward reported that the weekly visit was sometimes late in the afternoon, when nursing staff and the NCHD were not readily available. The frequency of review of the nursing care plans varied from monthly to six monthly. All wards had an allocation of qualified nurses. Nursing staff informed the inquiry team that staffing was insufficient to undertake care plans. Demands on nurses due to staff shortage and inappropriate duties are noted elsewhere in the report. A clinical psychologist was making assessments of residents with intellectual disability in St. Bridget's ward to inform resettlement plans but he did not contribute to multidisciplinary care planning. Multidisciplinary team meetings were not standardised. There may only have been a doctor and a nurse present.

16.4.3 Residents under the care of the psychiatry of later life team were accommodated in St. Mary's ward. Review of residents' care took place at the weekly team meeting and at the weekly visit by the consultant psychiatrist to the ward. Nursing care plans were reviewed every six months, or more often, if required.

An occupational therapist worked in St Mary's ward for one session each week.

16.4.4 The rehabilitation team met every week in St. Teresa's ward. The consultant psychiatrist, NCHD, nursing staff, occupational therapist and clinical psychologist attended the meeting. Day to day problems were discussed and a programme of regular reviews had been introduced. Residents were invited to attend the meeting.

16.5 Future plans

16.5.1 The Clinical Director informed the inquiry team that the service aimed to implement a standardised format for care plans and this was part of the five year plan. There was a general agreement, locally, to work towards a combined care plan. Any member of the multidisciplinary team could write in the clinical case notes. A local multidisciplinary working group had reached agreement on the design of a composite case file but this was overtaken by HSE introducing a national patient chart throughout acute services. Members of the working group were unaware that this was under development. The first priority for combined case files would be St. Michael's Unit.

16.5.2 A detailed personal history, including information from carers or relatives, is an essential part of the assessment of a resident in long-term care. It can greatly assist in the planning of care and in enhancing communication with a person affected by dementia, mental illness or intellectual disability. Knowing the likes and dislikes, background and life history of a person greatly assists members of staff to provide good care. The recognition of the individuality of someone receiving care reduces the risk of institutional care practices. In St. Luke's Hospital personal histories of residents were hard to identify from the records, in almost all wards. It was very difficult to establish the background, personal likes and dislikes, and family background of residents. The Clinical Director informed the inquiry team that all residents' medical files should have contained a comprehensive case summary, including a personal history. This was identified as a priority the previous year and dictaphones and secretarial time had been made available to NCHDs for this purpose.

16.6 Comment

16.6.1 Most of the elements of multidisciplinary care planning were in place in St. Michael's Unit. It appeared that that the introduction of a single, composite system of recording was the main obstacle to its implementation.

16.6.2 A composite filing system was also needed in St. Luke's Hospital but the very low level of involvement of health and social care staff was the main obstacle to the introduction of multidisciplinary assessment and care planning.

16.6.3 The Report of the Inspector of Mental Health Services 2007 commented, *"No individual care plans were in use as defined in the Regulations. The care plans were nurse led and separate to the clinical file. A working group had been set up to address the need for for MDT care plans."* (St Luke's Hospital)

"Individual care plans as defined in the Regulations were not in use. Each resident had a nursing care plan and medical treatment plan. A number of residents had standardised assessments completed on admission." (St Michael's Unit)

St Luke's Hospital and St Michael's Unit did not comply with Article 15 "Individual care plan" of the Regulations.

16.7 Findings

16.7 a) A system of individual multidisciplinary care planning, based on comprehensive needs assessments, was not in place, although sector and specialist teams had the nucleus of a multidisciplinary team and residents could attend clinical meetings. (St. Michael's Unit)

16.7 b) There were separate medical and nursing notes, although composite records were planned.

16.7 c) The interventions specified in nursing care plans were not based on comprehensive needs assessments.

16.7 d) Many residents did not understand the keyworker system. (St. Luke's Hospital) There was no effective keyworker system to provide continuity of care. (St. Michael's Unit)

16.7 e) On most wards, doctors and nurses met regularly and addressed day to day clinical matters but a programme of regular psychiatric review was often not in place. (St. Luke's Hospital)

16.7 f) Clinical records generally contained little personal information about residents' backgrounds to inform needs assessments and the provision of person centred care. (St. Luke's Hospital)

16.7 g) Psychological assessments were carried out under a contract, rather than by a clinical psychologist appointed to the multidisciplinary team. (St. Bridget's ward)

16.7 h) Assessments, using the adaptive behaviour scale, will identify behaviours that may benefit from treatment programmes. Ward based staff have not been trained in the implementation of treatment programmes. Implementation and monitoring of treatment programmes will not be possible without continuing involvement of a clinical psychologist. (St. Bridget's ward)

17. THERAPEUTIC AND RECREATIONAL ACTIVITIES

17.1. This section outlines the legal requirements for and recommendations on the provision of activities at approved centres and describes the current provision in South Tipperary, which has been criticised in the Reports of the Inspector of Mental Health Services.

17.2 Background

17.2.1 The Mental Health Act 2001 (Approved Centres) Regulations 2006 (S.I. No. 551 of 2006), states that *"The registered proprietor shall ensure that each resident has access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan."*

17.2.2 *"The registered proprietor shall ensure that programmes and services provided shall be directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident."*

17.2.3 With regard to recreational activities the Regulations state *"The registered proprietor shall ensure that an approved centre, insofar as is practicable, provides access for residents to appropriate recreational activities."*

17.2.4 The Mental Health Commission's *Quality Framework-Mental Health Services in Ireland* Theme 1, Standard 1.5 is, *"Therapeutic services and programmes to address the needs of service users are provided."* The Commission proposed that services should begin to implement this standard during 2007. A realistic timeframe for full compliance should have been set during that year.

17.2.5 The *Report of the Inspector of Mental Health Services 2006* stated, *"The lack of therapeutic activities for the population of patients still remaining in St. Luke's Hospital remains a concern. There was only one occupational therapist in the entire service at the time of the inspection, although there were plans to recruit two further occupational therapists. There is no programme of individual needs-based therapeutic activities in St. Michael's Unit although there is a therapeutic and activity area on the unit and a variety of activities are offered by nursing staff."*

17.2.6 In making an assessment of therapeutic and recreational activities the inquiry team studied documents provided by the senior management team and interviewed members of staff. Residents were interviewed and medical and nursing notes were reviewed during visits to the wards. The team visited areas of wards where activities took place. As described earlier, clinical teams often lacked key personnel. Therapeutic programmes could only be provided to a limited extent because of this.

17.3 St. Michael's Unit

17.3.1 Nursing staff ran a programme of activities. Sessions were run during part of most mornings and some afternoons. These were provided by nursing staff and by organisations, such as advocacy, GROW, A.A. and Schizophrenia Ireland. An art therapist and staff from the local VEC provided art classes. Social work staff ran a Wellness and Recovery Action Plan group fortnightly for an 18 month period but informed the inquiry group that the group was on hold due to a difficulty with accessing audiovisual equipment. Senior managers disputed this. No occupational therapist was employed in the unit. The programmes provided were not individualised and did not appear to be linked to residents' assessed needs or wishes. At the time of the inquiry team visit, none of the residents attended activities off the ward. In the past, residents had attended the occupational department in St. Luke's Hospital or Cluain training centre in Clonmel.

17.3.2 A number of residents complained of boredom to the inquiry team, saying there was very little to do. They said that the nurse who facilitated the activities did her best but the range of activities did not meet their needs. They said that the nurse was not replaced during absence for leave or sickness. A survey of residents' views on activities is described in section 14. For much of the time there was little to occupy residents.

17.4 St. Luke's Hospital

17.4.1 The inquiry team was provided with an outline of activities for each ward. It was clear that some of these activities were not available regularly or frequently. Some wards provided a timetable for the day but there were few activities arranged and the day ended at bedtime, which was recorded as 8pm. The activities that were available were not individualised and did not appear to be linked to residents' assessed needs or wishes. In some areas it was clear to the inquiry team that there were not enough members of staff to provide sufficient care and attention to the residents, who spent their days sitting in the ward, looking bored and with little or nothing to interest them or to take part in. Most of them have lived in the hospital for many years, some

for most of their lives. There were no community meetings, apart from in St. Teresa's ward, in which residents had an opportunity to comment on their care.

17.4.2 In the continuing care wards (St. Kevin's, St. John's, St. Bridget's, St. Paul's and St. Clare's) there were no therapeutic programmes based on individual care plans. This may have been linked with the long term prescribing of benzodiazepines that is noted in the reports on St. Kevin's and St. Bridget's wards. Nursing staff facilitated activities when they could but there were often insufficient staff numbers. Day trips were arranged, when transport was available and when staffing permitted. Several residents attended the occupational department within the hospital grounds, which provided work-orientated activity, along with social and recreational activities.

17.4.3 Nursing staff in the psychiatry of later life ward, St. Mary's, endeavoured to provide activities with limited resources but the activities were clearly insufficient for the needs of the residents. There was little evidence of any person centred assessment of activity needs. An occupational therapist worked in the team on a part-time basis. Only one session of her time was allocated to St. Mary's ward.

17.4.4 An occupational therapist was recently appointed to work in the rehabilitation ward, St. Teresa's. Assessments for individual activity programmes were being carried out and activity sessions, involving cookery, recreation and community integration had commenced. Nursing staff continued to support an activity programme. Some residents attended activities outside the ward, several in the hospital occupational department and two at Cluain training centre in Clonmel. Transport was usually available and trips were organised. A number of residents had been on holidays during the past year

17.5 Comment

17.5.1 Key health and social care professional staff were often missing from multidisciplinary teams, particularly in St. Luke's Hospital. The teams could not, therefore, draw up individual multidisciplinary care plans, which would identify therapeutic activities that would be beneficial for residents.

17.5.2 Nursing staff and external agencies provided a limited range of recreational activities but there was no occupational therapist in most areas to provide residents with therapeutic programmes aimed at restoring or maintaining optimal levels of physical and psychosocial functioning.

17.5.3 In general there were few activities aimed at assisting residents' reintegration into the community.

17.5.4 The Report of the Inspector of Mental Health Services 2007 commented, *"A recreational therapy programme of activities was available. The service needed to develop therapeutic programmes based on individual needs assessments. No occupational therapists were attached to the general adult teams covering these wards."* (St Luke's Hospital)

"A recreational therapy programme of activities was available. All groups were open and no referral procedure was in place. No occupational therapy assessments or interventions were available." (St Michael's Unit)

17.6 Findings

17.6 a) The clinical teams had limited health and social care professional staff, reducing treatment options. (St. Michael's Unit)

17.6 b) There was a virtual absence of therapeutic activities. (St. Michael's Unit)

17.6 c) Nursing staff and personnel from outside agencies provided a limited programme of mostly recreational activities but this was insufficient to occupy residents for much of the time. (St. Michael's Unit)

17.6 d) Few activities were based on individual assessments or were designed to facilitate discharge, although these were being developed in St. Teresa's ward. (St. Luke's Hospital)

17.6 e) Residents were not often asked about their preferences for activities or offered alternatives. (St. Luke's Hospital)

17.6 f) Some residents attended the occupational unit but there was little to occupy most residents other than some activities and outings that were organised by ward staff. (St. Luke's Hospital)

17.6 g) Limited opportunity for exercise was a concern for a number of residents. (St. Michael's Unit)

18. SECLUSION, RESTRAINT AND OBSERVATION

18.1 This section describes the legal background and current policies and practice regarding the use of seclusion, restraint and other limits to freedom. The interrelated subjects of observation practice, the use of restraint, locked doors and the wearing of nightclothes are described.

18.2 Seclusion

18.2.1 Section 69 of the Mental Health Act 2001 and its associated Rules govern the use of seclusion. Section 69 (1) of Act states, *"A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules."*

18.2.2 Seclusion is defined for the purposes of the Rules as, *"the placing or leaving of 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."* Paragraph 2.1 states, *"Seclusion must only be used in the best interest of the patient and only when a patient poses an immediate threat of serious harm to self or others and all alternative interventions to manage the patient's unsafe behaviour have been considered."*

18.2.3 At the time of the inquiry team visit, seclusion was used as an intervention in St. Luke's Hospital and in St. Michael's Unit. Three wards in St. Luke's Hospital had seclusion rooms; St. Bridget's, St. John's and St. Kevin's. There was a seclusion room on both the male side and the female side of St. Michael's Unit.

18.2.4 Following the recommendation contained in the Inspector of Mental Health Services' Reports of 2005/2006 regarding seclusion, the Clinical Director, on taking up appointment, carried out an audit of seclusion, comparing the use of seclusion in 2005 with the use in 2006 and the use between January and June 2007. The audit quotes the Royal College of Psychiatrists statement that "*Seclusion is not therapeutic and should be an exceptional event in all psychiatric units involved in the management of disturbed and violent patients" (CR41 RCPsych, 1995).* The inclusion of this quote in the audit indicates that this is the view of the managers of the service. The inquiry team have used this statement and the Mental Health Commission rules as the basis for the examination of the use of seclusion in St. Michael's Unit and St. Luke's Hospital.

18.2.5 The audit covering 2005 noted that nine per cent of seclusions took place because of staff shortages. It also identified that the recording of the starting time of the episode of seclusion was unclear in some cases and some signatures were not legible. The average length of time of seclusion was higher in St. Michael's Unit and in St. Luke's Hospital than that in UK and French data.

18.2.6 South Tipperary mental health services developed a policy on the use of seclusion in July 2007 and this was approved on 3rd August 2007. The new seclusion policy included provision for the "de-briefing" of residents and the provision of information about seclusion.

18.2.7 The inquiry team discussed the use of seclusion with senior nurses and medical staff. During those discussions individual staff members made the following comments:

- It is custom and practice.
- It is an alternative to sedation (there was no audit information to confirm this view).
- The threshold is too low; it can be used for verbal aggression and as a first line intervention.
- Staffing levels at certain times of the day leave little alternative.
- The design of St. Michael's Unit, particularly the high observation areas, is unfit for purpose and prevents the use of other strategies.
- Lack of activity leads to boredom and frustration of residents.

18.2.8 When the inquiry team met consultant psychiatrists, some said they had refused to authorise the use of seclusion on several occasions. There was an acknowledgement that greater care needed to be taken to properly record the reasons for the use of seclusion. The local audit did not establish how often authority for seclusion was withheld nor identify the reasons for refusal.

18.2.9 St. Luke's Hospital and St. Michael's Unit had a policy on the reduction and management of aggression and associated training but training for the trainers was suspended at the time of the inquiry team visit. However, seclusion or restraint did not appear to be monitored through clinical governance systems.

18.2.10 The local audit made a number of recommendations, including greater clarity on the use of seclusion, improved staff awareness and training, improved documentation, a review of all incidents of seclusion at clinical team meetings, a programme of day-time activities and an "inbuilt audit".

18.2.11 The inquiry team examined seclusion records in all the wards that continued to use seclusion and the records of some residents who had been secluded. The records in St. Michael's Unit were examined more closely because it was the area with the most frequent use of seclusion. A sample of seclusion records were examined there to ascertain whether the rules relating to the use of seclusion were being followed and whether the records gave a clear indication of whether seclusion was an appropriate intervention. Below is a summary of the use of seclusion.

18.2.12 St. Michael's Unit

Of the 49 entries in the St. Michael's Unit seclusion register (in use since November 2006), 39 were for men and 10 for women. Of the 49 episodes, 34 gave the name of the member of staff who initiated the episode and 46 gave a brief description of why seclusion was necessary. A description of alternatives to seclusion, which had been considered, was given in 28 cases. In 31 episodes an end time for the seclusion was given. In one case there was no authorising signature and in another it was indecipherable.

Many of the entries made no reference to the threat of serious harm. Many entries recorded no consideration of alternatives to seclusion and those that did gave cursory descriptions that did not indicate serious consideration of alternative interventions.

One example of this was an entry, which stated that the resident had been secluded because he was, *"interfering with other patients property and pulling out bedclothes causing some to be frightened"*. The alternative intervention to seclusion was recorded as, *"Attempted to persuade… to remain in bed but to no avail"*.

18.2.13 St. Bridget's ward

The team met one resident who had been secluded frequently in the past. A new approach, described in the section on the ward, had been initiated by nursing staff and this was successful and seclusion was no longer considered necessary. Only one episode of seclusion was recorded since the Rules came into effect.

18.2.14 St. Kevin's ward

The seclusion room was no longer used.

18.2.15 St. John's ward

The seclusion room was used occasionally. The team was told that staffing was increased in St. John's ward at night, and this had reduced the need for the use of seclusion. Only one resident was secluded with any frequency.

18.3 Restraint and limits to freedom

18.3.1 The Mental Health Commission Code of Practice on the Use of Physical Restraint in Approved Centres sets out best practice to ensure the requirements of the 2001 Act are met. Section 7 of the Code of Practice refers to the need for approved centres to have a policy and procedures for training staff in relation to physical restraint. The inquiry team was concerned to hear that nurse managers had informed trainers in the management of aggression that, because of general staff shortages, they would be released to attend training to maintain their qualifications but they would not be released to provide training at other centres. The inquiry team wrote to the senior management team and were subsequently assured that staff training would be maintained.

18.3.2 The use of bed rails and lap belts in St. Clare's and St. Mary's wards was covered by appropriate policies and was in line with the Commission's rules.

18.3.3 There was a local policy on the use of physical restraint. Use of physical restraint appeared to be in line with Commission's code of practice.

18.4 Observation levels and residents wearing nightclothes

18.4.1 The Mental Health Act 2001 (Approved Centres) Regulations 2006 (S.I. No. 551 of 2006) article 7 requires the registered proprietor to ensure that nightclothes are not worn by residents during the day, unless specified in their individual care plans.

18.4.2 On the day of the inquiry team's visit to St. Michael's Unit, 13 of the 21 male residents and 16 of the 29 female residents were on raised levels of observation. All of the residents on raised level of observation were required to wear nightclothes. This requirement was not

recorded in the residents' care plans. Staff said that residents on raised levels of observation were required to wear nightclothes. The only clear reason given was to reduce the possibility of an "at risk" resident leaving the unit.

18.4.3 The inquiry team noted that all residents being cared for in the locked high observation area were on raised levels of observation, and were required to wear nightclothes. Given that the only reason put forward for requiring a resident to wear nightclothes was to reduce the risk of him or her leaving the unit, the inquiry team could not see the justification for this practice in the high observation areas.

18.4.4 The observation policy, like that of many services in Ireland, is largely based on regular intermittent checks of a resident's whereabouts, which, by itself, is an unproven method of maintaining residents' safety.

18.5 Locking of wards

18.5.1 Four of the wards visited were permanently locked. The male and female high observation areas of St. Michael's Unit were also locked for much of the time. Neither the wards that were locked nor the hospital had a policy in relation to the locking of doors. There was no written guidance for residents or visitors on why doors may be locked. In the wards that were permanently locked there appeared to have been no consideration of alternative methods of protecting "at risk" residents.

18.6 Comment

18.6.1 To lock someone in a room, alone, is such a serious measure that it must be carefully regulated and monitored. It is likely to have a significant impact on the person who is subjected to it. In managing any disturbed behaviour staff have to balance the risk to a resident and to others against unnecessary restriction and deprivation of freedom.

18.6.2 Many factors may influence the likelihood of seclusion being used, not least the knowledge, training and attitudes of staff in relation to the management of violent and aggressive behaviour. In a care setting where seclusion is likely to be considered there must be a policy and associated procedures for the prevention and management of violent and aggressive behaviour. Staff must be trained and regularly updated on the principles of reducing violence and aggression and on the use of physical restraint. The policy should set out clear courses of action for staff

and managers. Seclusion should be one of a range of alternatives for managing disturbed and dangerous behaviour.

18.6.3 Many of the staff of St. Michael's Unit recognised that the incidence of seclusion could have been reduced and identified a number of factors that appeared to increase its use. The inquiry team believes that there is an opportunity in St. Michael's Unit, with clear leadership and support to staff, to greatly reduce and, perhaps, completely eliminate the use of seclusion, by identifying what lies behind its use and by supporting staff to use alternative approaches to the reduction and management of disturbed and aggressive behaviour.

18.6.4 A requirement to wear nightclothes does not promote the treatment of residents with dignity and respect and is likely to encourage residents to adopt a passive and dependent attitude to care. 29 of the 50 residents of St. Michael's Unit wore nightclothes at the time of the inquiry team visit.

18.6.5 A radical review of the assessment and management of clinical risk is necessary. If the recommendations of A Vision for Change are implemented there will be approximately 18 mental health admission beds for the population of Tipperary. This highlights the unnecessary degree of restriction placed on people by current practices, given that the majority will be cared for by community services in the future.

18.7 Findings

18.7 a) Seclusion was used more often than necessary. Alternatives to seclusion were not always fully considered and an immediate threat of serious harm was not always present. (St. Michael's Unit)

18.7 b) Lack of activities for residents, staff shortages and inadequate ward layout made the use of seclusion more likely. (St. Michael's Unit)

18.7 c) The end of periods of seclusion was not recorded consistently. (St. Michael's Unit)

18.7 d) There had been no audit of the need for the use of seclusion.

18.7 e) As far as the inquiry team could ascertain, a raised level of observation was invariably accompanied by wearing nightclothes and this was unnecessarily restrictive. (St. Michael's Unit)

18.7 f) Ward doors were locked without careful consideration of each resident's needs, and without full consideration of all alternatives, resulting in unnecessary restriction of freedom. (St. Luke's Hospital)

18.7 g) There was a culture of risk avoidance, leading to blanket restrictions, rather than specific responses being based on individual risk assessments.

19. STAFFING

19.1 This section describes current staffing arrangements and how well these address the needs of the residents of St. Michael's Unit and St. Luke's Hospital. The information came from documents made available to the inquiry team and from interviews with managers and staff members.

19.2 Medical Staffing

19.2.1 Medical staff working in South Tipperary mental health services were either consultant psychiatrists or Non Consultant Hospital Doctors, working under their supervision. At one time general practitioners contributed to the care of long-stay residents of St. Luke's Hospital but this arrangement had lapsed by the time the inquiry team visited.

19.2.2 Consultants

Each of the three community mental health teams was led by a consultant. In addition, a consultant, providing locum cover, had been in post for some years. The teams covered geographical sectors, parts of which were some distance from the hospital. One of the teams was based in Tipperary. A number of clinics were held in other locations in South Tipperary. The consultants were responsible for the care of residents of St. Michael's Unit, who had been admitted from their sector, for the residents of five long-stay wards in St. Luke's Hospital and for residents of a number of hostels and community residences in South Tipperary. One consultant had administrative responsibility for electro-convulsive therapy and another was clinical tutor for the trainee psychiatrists. The inquiry team was informed that all consultant psychiatrists worked entirely within the health service.

The consultant psychiatrist in rehabilitation worked half time as Clinical Director and was responsible for the care of residents of St. Teresa's ward. Before her appointment, in, November 2005, the Clinical Director post had been unfilled since 2001, apart from one year, when one of the consultant psychiatrists acted as Clinical Director, in addition to undertaking her clinical work. In child and adolescent psychiatry there was a consultant (0.4wte) in addition to the full-time substantive consultant. Their work was entirely community based. The consultant in the psychiatry of later life was responsible for the care of residents of St. Mary's ward, in addition to community-based work.

The inquiry team was informed that funding was available for continuing medical education as specified in consultants' contracts.

19.2.5 Non consultant hospital doctors

Eight trainees worked under the supervision of the consultant psychiatrists. They provided day to day care for residents of St. Luke's Hospital and St. Michael's Unit. The trainees were attached to the sector teams and to the rehabilitation, child and adolescent psychiatry and psychiatry of later life teams. Training locally was approved, and funded, for two of the required three years of psychiatric training. Some years previously this approval was lost, temporarily, and the clinical tutor was concerned that local facilities did not currently meet educational standards because of inadequate library facilities. Although internet access and relevant mental health books and journals were available at St. Luke's Hospital, the library had been given over to office use and the library at South Tipperary General Hospital did not subscribe to the relevant journals.

19.3 Nurse Staffing

19.3.1 The Director of Nursing post had been filled in an acting capacity since 2006. Nurse staffing for St. Luke's Hospital and St. Michael's Unit was operationally managed by the four assistant directors of nursing (ADONs) and by a Clinical Nurse Manager (CNM3) at night. The ADONs spent around 70 per cent of their time maintaining staffing for the wards. The ADONs reported that nurse staffing was 20 per cent below requirements. Two years earlier a rostering system was implemented, aimed at meeting service and staff needs. An audit indicated that around 80 per cent of staff needs had been satisfied. The ADONs reported that this system was, however, very rigid to manage. Consideration was being given to devolution of staff management to ward level. The rostering system did not appear to have been developed with the assessed needs of residents as its primary focus.

19.3.2 The shift pattern for all wards was 0800hrs – 2030hrs or 0800hrs-1800hrs. In most wards there were two nurses on duty 1800hrs-2030hrs. The CNM was rostered as part of the daily establishment for all wards. St. Michaels' Unit had two staff rostered on each side at night. Additional staff were provided to meet clinical demands. In several wards it was reported that staff were often transferred to cover other areas, leaving the ward with less than the agreed minimum staffing. Overtime was used extensively to meet basic levels of staffing.

19.3.3 Each ADON had specific areas of responsibility for the community sectors and the wards. However, due to the time demands of managing the staffing "desk" they did not feel they had sufficient time to develop and support their areas of responsibility, including clinical supervision.

19.3.4 While there were domestic staff, a significant proportion of qualified nursing staff time was taken up with non-nursing duties. Student nurses were allocated to work on wards from time to time . Some residents were required to go to bed earlier than they wished, in one case at 4.30pm. Outings were restricted by staff shortage. Staff time to develop therapeutic and recreational activities was restricted. It was suggested to the inquiry team, and previously identified in a local audit on seclusion, that some episodes of seclusion had been directly related to inadequate staffing levels.

19.3.5 In a response to a draft of the inquiry report senior managers stated that, since 2006, inadequate staffing levels had not been a reason for seclusion. They also stated that they had made proposals on changes to skill mix to staff associations but these had not been agreed. There is now a national agreement regarding the introduction of healthcare assistants. Senior managers informed the inquiry team that they endeavoured to have these arrangements applied in negotiations with local trade union representatives.

19.3.6 All nursing staff were qualified but residents with intellectual disability were usually cared for by nurses who were not qualified in intellectual disability nursing. Some of the staff had trained in behaviour therapy or psychosocial intervention. This training may have been useful in day to day practice but there was no structure for the application of these techniques. Training was not co-ordinated at ward level. The onus was on individual staff to identify their training needs. There were problems in providing mandatory training for all staff. The ADONs reported that it was a challenge to release staff for the five day control and restraint training. A clinical risk management report noted that only one quarter of the staff on duty at the time of a death had attended resuscitation training in the previous two years.

19.4 Health and social care professionals

19.4.1 Clinical psychology

There were three clinical psychologists in the service. One was acting Principal and was attached to the Tipperary sector, provided limited input to the rehabilitation team and had managerial and supervisory responsibilities. A temporary basic grade psychologist was attached to the Clonmel East sector and provided four hours per week to the Clonmel West team, which had a vacant full-time post. A senior clinical psychologist was a member of the child and

adolescent psychiatry team but there was no psychologist attached to the psychiatry of later life team.

The psychologists had access to clinical supervision. Funding was available to attend a variety of educational events and to purchase equipment, test and other items they required. There were links between the psychology department and the clinical training courses in University College Dublin and University of Limerick.

19.4.2 Social work

There were four social workers in the service. The Team Leader was attached to the Clonmel East team, one basic grade social worker was attached to the Tipperary sector team and another to the Clonmel West team. A full-time basic grade post had been approved for the psychiatry of later life team. A senior social worker was a member of the child and adolescent psychiatry team but no social worker was attached to the rehabilitation team or the psychiatry of later life team.

Clinical supervision was available for the social workers. There was funding available to attend a variety of educational events.

19.4.3 Occupational therapy

Two occupational therapists worked in the service. A senior occupational therapist was attached to the psychiatry of later life team. Her work was mainly in the community. A full-time basic grade occupational therapist was based in St. Teresa's ward and was a member of the rehabilitation team.

Supervision was available for the occupational therapist but only limited supervision was available for the senior occupational therapist, from colleagues in the region. Funding was available for educational events and for necessary equipment, although it could take a while for equipment to arrive.

19.5 Clinical Governance

19.5.1 The Clinical Director informed the inquiry team that there was no formal clinical governance structure but a working group had been set up to advise on appropriate developments. As noted above, funding was usually made available for professional staff to

attend continuing education and professional development courses or events. There was a problem in releasing staff to attend all the mandatory training and clinical supervision, required by nurses, because of staff shortages. NCHDs no longer had adequate access to library facilities because of shortage of accommodation.

19.5.2 Some audits of nursing practice had been carried out and there had been an audit of admissions to St. Michael's Unit.

19.5.3 The Clinical director said there was a possibility of developing a clinical pharmacy service but this was uncertain.

19.6 Staffing developments

19.6.1 Proposed staffing developments, for the longer term, were outlined in the five year plan. The aim was to provide a community service as outlined in *A Vision for Change*. In July 2007, HSE South expressed an intention to develop a coordinated regional plan, incorporating local plans. Some members of staff said this appeared to put the local five year plan on hold.

19.6.2 The focus of South Tipperary mental health services must transfer to the community if the proposals in *A Vision for Change* are to be achieved. One of the major tasks faced by the service is the equipping of staff, predominantly nurses, for the very different challenges of community work.

19.6.3 More immediately, HSE placed an embargo on recruitment because of financial pressures. A number of approved posts were affected, although the appointment of two clinical psychologists to the community teams was already delayed because of a lack of accommodation for them.

19.7 Service management

19.7.1 Nurses were represented on the senior management team by the acting Director of Nursing and medical staff by the Clinical Director. There was no health and social care professional on the team but future management arrangements were under discussion. Health and social care professional staff were members of the management team of St. Michael's Unit.

19.8 Service provision to St. Luke's Hospital and St. Michael's Unit

19.8.1 This is described in detail in the relevant sections of this report. In St. Michael's Unit professional staff, who also had a significant commitment to community teams, made a major contribution. As described elsewhere there were, however, serious gaps in the service to residents.

19.8.2 Nursing staff were, by far, the largest group of care providers in both areas, as would be expected. With few exceptions, they were the only members of staff regularly involved in the care of residents of St. Luke's Hospital. Medical staff were the only other professional group with a defined responsibility to the long-stay wards and other commitments limited their involvement there.

19.9 Comment

19.9.1 It was suggested to the inquiry team that residents would benefit from the provision of general medical care by general practitioners. The inquiry team accepted this but believed that satisfactory medical care could be provided through existing arrangements.

19.9.2 Nurses spent a significant amount of time carrying out tasks that did not require their level of qualification. Qualified nurses carried out domestic tasks that could have been carried out by others. In consequence, they spent less time in providing individual care to residents, carrying out assessments and providing a range of appropriate activities. CNMs spent part of their time as ward nurses and had little opportunity to provide clinical supervision to staff and to develop ward nursing care practice. In the absence of self-staffing, ADONs spent much of their time organising staff rosters; currently this is largely a clerical task. They had very little time to develop their roles in supervision, in service development and as clinical leaders.

19.9.3 Proposed service development will require the recruitment of additional health and social care staff. Careful consideration will need to be given to the grading of the additional posts, to ensure that sufficient numbers of senior staff are available to provide supervision for junior staff and for students on clinical placement. The recommendations from the HSEA's reports on health and social care professions 2000 and 2002 should be taken into account.

19.9.4 There is a national shortage of clinical psychologists. The service may well need to engage with clinical training programmes and seek funding for trainee posts in line with its manpower needs for future years.

19.10 Findings

19.10 a) Competing clinical commitments reduced the availability of consultant psychiatrists and compromised their ability to provide clinical leadership. (St. Luke's Hospital)

19.10 b) There was a serious shortage of trained nurses and unexpected absences led to nurses being transferred from one ward to another, at short notice, reducing staffing levels and disrupting the care of residents. (St. Luke's Hospital)

19.10 c) Nursing time was taken up by tasks, such as laundry and catering, which could have been done by others. This, together with staffing shortages, limited the ability of nurses to provide personal care to residents, or to organise activities. (St. Luke's Hospital)

19.10 d) There was no systematic provision of clinical supervision for nursing staff.

19.10 e) Nurses who had trained in the use of psychosocial interventions and behaviour therapy were unable to use this expertise effectively. (St. Luke's Hospital)

19.10 f) A training needs assessment had not been completed, with the result that it was not clear that nursing staff received training appropriate to their area of work.

19.10 g) The clinical teams had limited health and social care professional staff, reducing treatment options. Lack of occupational therapists contributed to a virtual absence of therapeutic activities. (St. Michael's Unit)

19.10 h) There was very little involvement of health and social care staff and so there were, effectively, no multidisciplinary needs assessments, care plans or therapeutic activities. (St. Luke's Hospital)

19.10 i) Psychological assessments were carried out under a contract, rather than by a clinical psychologist appointed to the multidisciplinary team. (St. Bridget's ward)

19.10 j) Assessments, using the adaptive behaviour scale, will identify behaviours that may benefit from treatment programmes. Ward based staff have not been trained in the implementation of treatment programmes. Implementation and monitoring of treatment programmes will not be possible without continuing involvement of a clinical psychologist. (St. Bridget's ward)

19.10 k). There had been no assessment of residents' needs to inform workforce planning or staff training. A CNM3 post was created to develop a programme of assessments of residents for the purpose of discharge planning.

19.10 l) There was no formal clinical governance structure at the time of the inquiry team visit, although a working group had been set up to advise on appropriate developments.

19.10 m) Library facilities for NCHDs were unsatisfactory.

20. HOSPITAL ENVIRONMENT

20.1 This section describes the environment within St. Michael's Unit and St. Luke's Hospital at the time of the visits made by the inquiry team.

20.2 Background

20.2.1 The *Report of the Inspector of Mental Health Services 2006* states, *"The environment of St. Luke's Hospital is poor. Most areas are bleak, poorly decorated and institutional in appearance."* Concern about the environment in which residents were receiving care was one of the factors that led to the setting up of the inquiry.

20.2.2 The *Quality Framework for Mental Health Services in Ireland,* Standard 4.1 specifies, *"Service users receive care and treatment in settings that are safe, and that respect the person's right to dignity and privacy."* The Mental Health Act 2001 (Approved Centres) Regulations 2006 (S.I. No 551 of 2006) article 21, relating to privacy, and article 22, on premises, are particularly relevant to this section of the inquiry report.

20.2.3 As well as assessing the wards' general condition against previous inspections, the regulations and the standards of the Quality Framework the inquiry team wished to observe what recent efforts had been made to make the wards, particularly in St. Luke's Hospital, more homely and pleasant to live in for residents. In any long-stay hospital setting, where residents live in a communal manner, staff have to work hard to reduce the institutional pressures against individualised care. The environment must be as individualised as possible to help residents feel that they have their own space and that their personal needs and privacy are respected. The environment, regardless of plans for the hospital's future, must be maintained to ensure that residents are, as far as practicable, living in homely and comfortable conditions.

20.2.4 Being treated with dignity and respect was one of the strong messages from service users who were consulted in *A Vision for Change*. That was one of the overarching principles the inquiry team used in judging the environments that were visited.

20.2.5 The inquiry team noted that some very recent efforts had been made by managers to improve the environment. In a number of wards new furniture had been purchased and long-standing deficits had been repaired. Residents and staff welcomed these actions.

20.2.6 Set out below are specific matters of concern that the inquiry team identified during its visits and from discussions with residents and staff.

20.3 St. Luke's Hospital

20.3.1 Appearance and décor

Poor decor and an appearance of neglect were apparent in many of the areas visited. The team heard of difficulties in getting repairs carried out. In many areas the décor appeared bleak, uninviting and institutional. Peeling paintwork and evidence of old leaks was apparent in a number of areas. While the design of the wards was a limiting factor, much more could have been done to make the general appearance softer, warmer and more inviting.

20.3.2 Flooring

In many wards defective flooring was evident, which presented trip hazards. Some floors had been repaired but staff told us that responses to requests for repairs were often very slow. Staff drew attention to problems with flooring in St. Paul's, St. Clare's and St. Mary's wards.

20.3.3 Personal space

This was extremely limited in all wards. In many wards some personal clothing had to be stored communally. In St. Paul's ward some of the clothing storage was in a bathroom. As well as the practical problems of not being able to have clothes and belongings accessible this limited opportunities for residents to personalise their areas. Many of the single rooms had very limited storage space. Some wards provided lockable storage for residents but others did not. Generally the inquiry team was struck by the poverty of residents' personal areas and how few personal photographs and mementos were apparent.

20.3.4 Day areas

In some wards efforts had been made to improve day areas with new furniture. However, many day areas could have been made more homely, with focal points, quiet areas and creative decoration to soften the environment. Better curtains and improved lighting would also have been beneficial. Several wards did not have an area where residents could go for peace and

quiet, which is essential for anyone who is living in a communal setting and should be available to all residents.

20.3.5 Outside areas

It was surprising to see the very limited access to safe garden areas. This seemed ironic, given that one advantage of an old hospital site is that there is space available that can be used creatively. Most of the outside areas available to residents were constructed mainly of concrete and were bleak and uninviting.

20.3.6 Bathroom and toilet areas

In many wards the bathroom and toilet facilities were completely inadequate in quantity, quality and design. Lack of disabled access toilets, over-dependence on commodes, limited access to hand washing facilities for staff and residents and inaccessible showers were some of the practical problems reported. In one ward two residents used the bathroom area at the same time, only screened by curtains. There was evidence of poor ventilation in bathrooms, resulting in extensive peeling paint. The inquiry team felt the bathroom areas were very institutional, with little evidence of softening the environment to make bathing a more pleasant and relaxing experience for residents.

20.3.7 Access to kitchen areas

None of the wards visited allowed residents access to areas where they could make drinks or prepare snacks, either as a general facility or as an area for support in developing activities of daily living. It appeared that staff took a blanket view that it would be too risky to allow access to such facilities. No specific risk assessments had been undertaken to support this view. The inquiry team thought that it was likely that many residents would like to have, and would benefit from, access to kitchen facilities.

20.3.8 Bedroom and dormitory areas

Bedrooms and dormitory areas are a particularly personal space for residents. The comments made earlier about personal space apply to bed areas. Far too many of the bedrooms and dormitory areas were bare, with very limited evidence of personal possessions, or were designed in a way that did not identify the area as personal space. Most dormitories appeared highly institutional. Some areas provided locking storage but not all. Clothing stored away from

residents' personal areas made it difficult for residents to have any sense of ownership of their possessions or clothing. Some sleeping areas had no curtains around the beds or over the windows. In one ward viewing panels into single rooms had no curtains that could be used by residents for privacy. Staff in one ward said that a report to Health and Safety representatives was required before appropriate beds were purchased for patients with impaired mobility.

20.3.9 Private visiting space

Article 11(1) of the Regulations requires the registered proprietor to ensure that appropriate arrangements are made for residents to receive visitors. There were pleasant, private areas for visiting in some wards but St. Paul's ward had an inadequate area for visiting.

20.4 St. Michael's Unit

20.4.1 The inquiry team's report on this unit set out some of the specific concerns about the environment. In general the environment was bleak and uninviting and the inadequate dining facilities adversely affected patient care. There was insufficient space for therapeutic activities and this was recognised by staff and residents.

20.4.2 In the high observation areas on the male and female sides of the unit up to six unwell and disturbed residents were obliged to live in close proximity in a cramped, dirty and unpleasant area. At the time of the team's visit at least one resident was smoking by his bed, making the atmosphere unpleasant. The single room area on the male side was dirty, had an unpleasant odour and looked grim. Both observation areas appeared intimidating and would not provide reassurance to anyone being admitted or to their relatives.

20.4.3 In the high observation areas, residents' personal space was restricted to the area on and around their bed. An essential part of reducing stress in an admission ward is to give residents some opportunity to choose and vary their company, especially to give respite from difficult relationships and conflict. The layout made this very difficult to achieve. One resident said that he found this part of the ward very hard, like a prison.

20.4.4 There was no visiting area in St. Michael's Unit. Bedrooms and the limited day areas were used for visits.

20.5 Maintenance

20.5.1 Article 22 of the Regulations requires the registered proprietor to ensure that:

"(a) premises are clean and maintained in good structural and decorative condition;

(b) premises are adequately lit, heated and ventilated;

(c) a programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and implemented and records of such programme are maintained."

20.5.2 Ward staff repeatedly commented on delays in getting maintenance carried out. The delays meant residents had to put up with inadequate and potentially dangerous facilities and staff were left frustrated by the length of time for a response. Staff in the wards said they did not know whether there was a programme of refurbishment and redecoration. They had the perception that resources were scarce and this perception discouraged them from making requests for improvements.

20.5.3 The Hospital Manager informed the inquiry team that he held the overall budget and there was no ward based budgeting. He reported that he was "not overwhelmed" with requests for minor capital works that were aimed at improving the environment. Replacement of soft furnishings was not classed as minor capital work and funding came from the replacement budget. There were five or six areas within the hospital where replacements were being specifically addressed. He referred to the problems with showers in St. Michael's Unit and outlined the investment being made there. He was clear that resources were available and that no proposal had been rejected. He said that the maintenance department, which also served the acute hospital service, had limited capacity for extra work and this caused delays in improvement work being carried out. The maintenance budget was regularly exceeded in an effort to keep the hospital environment and infrastructure in as reasonable condition as possible.

20.6 Comment

20.6.1 The closure of St. Luke's Hospital sets something of a dilemma for the managers of the service. In any hospital closure programme a balance has to be struck between maintaining the fabric of old buildings, providing a fresh environment and not spending large amounts of public money on facilities that will only be in use for a short period of time.

20.6.2 At the centre of this dilemma are the expectations, rights and needs of the residents of St. Luke's Hospital. As well as a place of care and treatment the hospital is their home. This report criticises the poor quality of the environment in the hospital and highlights its austerity and lack of homelike qualities. It is old fashioned and a relic of an era of institutional care practices.

20.6.3 What must be avoided is the nihilistic view that there is little point in spending money on the hospital, as all the residents will soon have left. This is particularly important when a closure date has not been identified and may be some time away. Real improvements could be made by fairly straightforward and relatively inexpensive developments. Creative approaches could greatly enhance what it is like to live in St. Luke's Hospital, without inappropriate or excessive expenditure.

20.6.4 The Report of the Inspector of Mental Health Services 2007 commented, *"Since the last inspection a programme of refurbishment was in progress throughout the hospital. All wards were clean, bright and well heated on the day of the inspection."* (St Luke's Hospital)

"The building was in need of repainting and structural changes to a number of showers. It was reported that this work would commence in early 2008 following the awarding of a tender." (St Michael's Unit)

St Luke's Hospital and St Michael's Unit did not comply with Article 21 "Privacy" and Article 22 Premises" of the Regulations.

20.7 Findings

20.7 a) The decor of the unit was monotonous. In places the unit was poorly maintained, increasing the risk of injury to residents. (St. Michael's Unit)

20.7 b) Shortage of day space made it difficult for residents to find a quiet area or a place to meet visitors, as there was no designated visiting area. (St. Michael's Unit)

20.7 c) The locked, high observation dormitories were not suitable places to nurse severely mentally unwell residents during the day. (St. Michael's Unit)

20.7 d) The wards, including bedrooms, were generally painted in a single colour, giving a monotonous and institutional appearance to what was, in effect, the resident's home. (St. Luke's Hospital)

20.7 e) Most dormitories and bedrooms appeared bleak, some even lacked curtains, and there was little personal space for residents. (St. Luke's Hospital)

20.7 f) The day rooms generally had an institutional appearance and some were poorly lit, in contrast to St. Teresa's ward, where refurbishment demonstrated that these problems could be overcome. (St. Luke's Hospital)

20.7 g) Several wards had only one bathroom and the bathrooms and toilets generally appeared institutional in design and decoration. (St. Luke's Hospital)

20.7 h) Many of the enclosed external areas were unattractive. Most of the areas contained a few neglected plants and were surfaced with concrete. (St. Luke's Hospital)

20.7 i) Residents were put at risk by some ward layouts, which made observation and care difficult, and by damaged flooring and other defects. Long delays in completing repairs and maintenance compounded these problems. (St. Luke's Hospital)

20.7 j) Nurses and nurse managers were unclear about funding for improvements to the environment through minor capital works and extraordinary maintenance. They believed funding was not available but the Hospital Manager said this was not the case, although work was often delayed.

20.7 k) The maintenance budget was inadequate and was often overspent.

21. INTELLECTUAL DISABILITY SERVICE

21.1 This section outlines the national policy on services for people with intellectual disability. Present and proposed local services are described, along with concerns that have been expressed about them.

21.2 Background

21.2.1 *A Vision for Change* recommends that mental health services for people with intellectual disability should be similar to those for other citizens. Current services are largely provided by the voluntary and non-statutory sector and are focused on social, vocational, educational and residential needs; *"in general they do not deal with specialist mental health needs." A Vision for Change* recommends that appropriately staffed community mental health teams for people with intellectual disability should be developed. A team for adults should serve a population of 150,000 and a team for children and adolescents should serve a population of 300,000. In addition there should be a spectrum of services, including day hospital places, respite places and acute, assessment and rehabilitation beds. A range of interventions and therapies should be available within these settings.

21.2.2 The *Report of the Inspector of Mental Health Services 2006* noted that there were residents of St. Luke's Hospital with intellectual disability, *"throughout the hospital and these patients will now be accommodated in a dedicated unit as an interim arrangement pending the acquisition of specialist accommodation."* Later it was noted, *"There are no dedicated mental health teams within the intellectual disability service and no advance has been made on the situation outlined in the inspectorate reports of the past two years. The provision of the existing scant service is dependent on informal liaison between the psychiatrists themselves, and with general adult mental health teams. The lack of services has resulted in lengthy and inappropriate admissions of persons with intellectual disability to general adult mental health units and a lack of appropriate therapeutic care."*

21.3 Present situation

21.3.1 Below are extracts from the reports on ward visits made by the inquiry team in August 2007. They indicate that all long-stay wards at St. Luke's Hospital had residents with intellectual disability and residents with mental illness. There was no separate accommodation for the two groups.

21.3.2 St. Clare's ward: The primary diagnoses of residents were intellectual disability (five) and mental illness (15).

21.3.3 St. Paul's ward: Fifteen residents had a diagnosis of mental illness and seven had intellectual disability.

21.3.4 St. Mary's ward: Primary diagnoses of residents were: schizophrenia (six), bipolar disorder (four), intellectual disability (four) and dementia (seven).

21.3.5 St. Bridget's ward: Five residents had a diagnosis of mental illness and eight had intellectual disability.

21.3.6 St. Kevin's ward: The primary diagnosis of eight of the residents was intellectual disability and four had a mental illness.

21.3.7 St. John's ward: 18 residents had a primary diagnosis of mental illness and three had intellectual disability.

21.4 Local plans

21.4.1 A 'Nursing Assessment of Intellectual Disability patients residing within South Tipperary Mental Health Services', dated 23.4.05, noted that national policy, as set out in *Planning for the Future* recommended that those with intellectual disability should be cared for separately from those with mental illness and they should be offered a needs based programme of care and activity. An audit was carried out to as a result of concerns, expressed in the Inspector of Mental Health Services' reports, that residents with intellectual disability were dispersed throughout St. Luke's Hospital. 26 residents fell into this category, eight of them were from North Tipperary. They were accommodated in five of the seven wards, along with 133 residents with other diagnoses. Recommendations were made for one ward to specialise in caring for residents with intellectual disability or for care to be provided for small groups in the community.

21.4.2 A draft 'Relocation programme for individuals with ID from St. Luke's Psychiatric Hospital Clonmel', dated 15.6.07, noted that six residents had left the hospital during 2006 to move to accommodation provided by a voluntary organisation. A further resident left in March 2007. 29 individuals with intellectual disability remained in the hospital, including eight from North Tipperary. There were 18 men and 11 women. The paper briefly outlined preliminary

work that would be necessary to enable the residents to move to community care. Outline costs for a two year programme were provided.

21.4.3 At the time of the inquiry team's second visit, in October 2007, agreement was reached on opening the high support hostel in Cashel, after a long delay, and this opened subsequently, on 3.12.07. Following this, residents moved to the hostel from St. Teresa's ward and, following transfers of residents within the hospital, St. Kevin's ward closed and St. Bridget's ward became an interim intellectual disability ward. A multidisciplinary working group has been set up to oversee the move of residents from this ward to the community placements proposed in the local five year plan. Assessments of the needs of some of the residents, using the Adaptive Behaviour Scale have been carried out under a specific contract, although their value for care planning would have been greater if a psychologist who was a member of the clinical team had carried them out.

21.4.4 In the community, a voluntary organisation provided a residential intellectual disability service, under a service level agreement, at the time of the visit but there was no intellectual disability community team. One consultant psychiatrist had some experience in intellectual disability but no members of nursing staff were qualified in intellectual disability and no health and social care professional staff were employed in the service. There was no range of interventions and therapies as envisaged in *A Vision for Change*. As noted earlier, there was long-term use of benzodiazepines in some wards, which is not recommended in good practice guidance. This appeared to be a result of the lack of availability of other treatment approaches. The inquiry team was informed that advice was available from a specialist who worked for a voluntary organisation that provided some residential and community services in the area.

21.5 Comment

21.5.1. During the course of the inquiry, an interim intellectual disability ward opened, a year or more later than was envisaged in the local five year plan. Assessment of many residents has been carried out, with the intention of identifying appropriate accommodation in the community.

21.5.2 Until then, the residents will continue to receive care and treatment in an institutional setting. The staff caring for them are experienced but have had little or no formal training in intellectual disability and no health and social care professional staff are members of the clinical team, severely limiting, or preventing, needs assessments and the provision of therapeutic programmes and activities.

21.5.3 More than half the residents of two wards, many with intellectual disability, were prescribed long term treatment with benzodiazepines. The pattern of prescribing was not in line with good practice guidance issued by the Department of Health and Children in 2002.

21.5.4 The Report of the Inspector of Mental Health Services 2007 commented across the region, *"There were no dedicated in-patient facilities in this clinical area. There were four residential settings. All services reported that people with an intellectual disability were inappropriately treated in adult acute units and often remained there for long periods. There was no fully resourced clinical MDT in place to address the needs of this group..... People with a mild intellectual disability remained in acute psychiatric units without the expertise to meet their complex range of psychiatric and social needs."*

21.5.5 The Report of the Inspector of Mental Health Services 2007 later commented, *"An 18-bed ward specifically for residents of St Luke's Hospital with an intellectual disability was established through the amalgamation of two wards, St Bridget's Ward and St Kevin's Ward."*

21.6 Findings

21.6 a) Service provision by HSE South was limited to long term residential care. A voluntary organisation provided health care to some South Tipperary residents through a service level agreement.

21.6 b) There was no effective separation of residents with intellectual disability from those with mental illness in St. Luke's Hospital at the time of the inquiry team visit.

21.6 c) Members of staff were experienced but not qualified in the care of people with intellectual disability.

21.6 d) There was no intellectual disability multidisciplinary team and no needs based programme of care and activity.

21.6 e) Some residents received benzodiazepines on a long-term basis, which is usually considered to be undesirable. This was, at least in part, a result of a lack of activities and alternative treatment options.

21.6 f) Psychological assessments were carried out under a contract, rather than by a clinical psychologist appointed to the multidisciplinary team.

22. RISK MANAGEMENT AND INJURIES TO RESIDENTS

22.1 This section describes current clinical risk management arrangements and a report on injuries suffered by residents, which is dated 3 September 2004. That report raised the possibility that residents were at risk of injury because of non-accidental injury or poor care practices and this possibility contributed to the setting up of this inquiry.

22.2 Clinical risk management arrangements

22.2.1 Two clinical risk managers worked in South Tipperary mental health services. Previously they reported to the HSE Regional Risk Manager but, after a management reorganisation, one reported to the general manager of the PCCC, for St. Luke's matters, and the other to the General Manager of South Tipperary acute hospital services, who, however, had no governance responsibility for St. Michael's matters. A clinical risk management review group, which included the clinical risk managers, Clinical Director, acting Director of Nursing and a senior health and social care professional, had been established and it met every two weeks. The group considered incident reports and initiated investigations, where appropriate. The Local Health Manager and the acute services General Manager could also refer serious incidents to clinical risk managers for investigation. The investigation was carried out using root cause analysis, the aim of which is to identify possible underlying deficiencies. The investigation of trends in clinical incident reporting was hindered by a lack of statistical information, which will not be available until the national incident reporting database is in place. Previously, this information was available to senior managers through the HSE Regional Risk Manager.

22.2.2 The clinical risk managers analysed the findings of investigations, made recommendations to address any problems that were identified and reported on these to the clinical risk management review group. Assistant directors of nursing gave feedback information on the outcome of the group's consideration to ward staff. The senior management team took decisions on funding and disciplinary matters when these were required. The clinical risk managers believed that their recommendations often did not receive as prompt attention as they merited. They told the inquiry team that they would have preferred investigations to be carried out by a multidisciplinary team. They considered there to be a high number of clinical incidents that were not observed by members of staff.

22.2.3 The inquiry team was provided with a copy of a recent report on the death of a hospital resident, as an example of root cause analysis. To protect confidentiality only some of the general findings and recommendations are described:

- The report commented on deficiencies in recording in the medical and nursing notes, prescription charts and observation records. Failure to record changes of treatment and mental state, the reasons for the changes, their timing and who recorded them made it very difficult, or impossible, to track the sequence of events associated with an adverse event.

- At the time of the death, staff sickness and general staff shortage led, at short notice, to the ward being largely staffed by nurses who normally worked in other wards. Nursing tasks were not allocated according to the local policy. The report made recommendations to audit the level of staff shortages and to review the system of staff rotation, so that problems could be anticipated and resolved locally.

- 75 per cent of the staff on duty at the time of the death had not received resuscitation training within the previous two years. Problems were identified with the resuscitation equipment.

- An environmental risk assessment was recommended in order to identify potential hazards to residents.

22.2.4 That report and the following report on fractures sustained by residents commented on deficiencies in clinical recording, which seriously hindered both investigations, and on a need for risk assessments to play a greater part in clinical practice.

22.3 Report on fractures sustained by residents

22.3.1 That report is entitled 'Aggregate root cause analysis of fractures recorded July 2002 to 31st January 2004 in St. Luke's Hospital Clonmel Co. Tipperary'. It reported on an investigation into fractures in St Luke's Hospital and St. Michael's Unit and is dated 3 September 2004. The report stated that the acting Regional Clinical Risk Manager - Operations and the Regional Risk Manager carried out the investigation because "It was noted over time that a trend was beginning to emerge involving the occurrence of fractures in St. Luke's Hospital Clonmel, which were significantly different from other types of fractures seen in other similar facilities in the region." The investigation concluded, "On review and analysis of patients' clinical records there was insufficient documentary evidence to make an overall judgement from a clinical risk management perspective of any common root causes for these fractures."

22.3.2 During the 18 month period covered by the September 2004 report 19 residents of St. Luke's Hospital and St. Michael's Unit suffered injuries that included a fracture. Only one of

these incidents was observed by a member of staff. Injuries occurred in almost all wards. In the appendices of the report data from St. Luke's Hospital and St. Michael's Unit (224 beds) was compared with data from the psychiatric hospitals of the other three districts in the South Eastern region. All the hospitals contained long stay, acute, intellectual disability and psychiatry of later life wards. 15 fractures occurred in one district's hospitals (178 beds) but there were only seven fractures in the hospitals of the other two districts (381 beds). In St. Luke's Hospital and St. Michael's Unit fractures affecting hands and feet seemed more common. Two of the 19 residents each had fractures on two occasions during the 18 month period and five of the residents had suffered earlier fractures. Two of the 19 residents had further fractures while the report was being written. Osteoporosis was noted on several x-rays, presumably related to age and, perhaps, lack of exercise and activity. The former Regional Risk Manager informed the inquiry group that she was concerned that the injuries may have been non-accidental or due to a poor standard of care.

22.3.3 The September 2004 report made a number of recommendations, based on the concerns that were identified. A number of these recommendations have also been made in the annual reports of the Inspector of Mental Health Services. The September 2004 report's recommendations included:

- An orthopaedic specialist should review the cases where there appeared to be a possibility of non-accidental injury.

- Staff rosters should be examined and cross-referenced with the incidents.

- The policy of caring for residents, with different needs, in one ward, should be reviewed. (Frail residents appeared to be at risk from disturbed residents in some wards.)

- The Regional Medical Records Officer should audit residents' medical records and members of staff should receive training in maintaining records in line with clinical practice guidelines. (The investigation was apparently hindered by the poor quality of some of the clinical records, including the incident reports, which did not always clearly identify members of staff who were present at the time.)

- There should be a greater emphasis on learning from incidents. (Simply recording and reporting is insufficient.)

- A clinical pharmacist should be employed and a medications management committee should be established. (This would encourage good prescribing practice.)

- Individual care planning, including activity programmes and risk assessment, should be introduced.

Several other recommendations, aimed at improving clinical practice, were made, including a review of the need for hospital care and for locking doors, the provision of medical care by general practitioners, the implementation of a falls prevention programme and the establishment of a hospital risk management group.

22.3.4 The Regional Risk Manager informed the inquiry team that she had pressed for a meeting to consider the report but this did not take place until July 2005, almost a year after the report was completed. Transfer of management responsibility from Health Boards to the HSE was taking place at this time and the responsibilities and authority of risk management were not entirely clear. In addition, the acting Clinical Director had resigned in 2003 and had not been replaced and there had been a recent industrial relations problem relating to nursing management. On 15 July 2005 a meeting of senior managers and clinicians was held to consider the report. The clinical staff who attended the meeting did not have access to the report until shortly before the meeting. Consultant psychiatrists expressed serious concern to the inquiry team that they had not been informed earlier of the possibility that residents were subject to non-accidental injury. The meeting was not minuted, although this was not unusual. Many of those attending were unclear about the authority of the meeting. At the meeting the Regional Risk Manager outlined the findings of the report and indicated that there was a strong possibility of non-accidental injury. The two consultant psychiatrists who attended the meeting informed the inquiry team that they believed that a combination of environmental factors, including a failure to promote physical activity, which was linked to the locking of wards and a lack of physiotherapy and occupational therapy, combined with a lack of consistent general medical care that was focussed on health promotion, were more likely causes than non-accidental injury by nurses. They said that they had sought improvement in these areas, without success, for years. Others who were present told the inquiry team that they also doubted whether non-accidental injury had occurred and it was noted that one other hospital, mentioned in the report, had a similar incidence of injuries to residents. The Director of Nursing said that there were serious problems with nurse staffing levels. She considered the problems to be a result of slowness in advertising posts, especially ward manager posts, high sickness rates and failure to deploy trained nurses where their expertise would best meet residents' needs. There was discussion at the meeting of whether the presence of health and social care professional staff on the wards would reduce potential risks to residents. The possibility of informing the Gardai was considered. The need for further investigation of the causes of the injuries and into the very high proportion of unobserved injuries was discussed and generally agreed. Some, but not all, of those who attended the meeting recalled being forbidden to discuss these matters with anyone else because of concerns about the effect on staff and possible distress to relatives. Information about the September 2004 report was not circulated more widely, although many members of

staff, who spoke to the inquiry team, were aware of its existence and uncertain of its outcome. Three items were agreed at the meeting. The first was that the Mental Health Commission should be informed of the findings of the report and the Regional Risk Manager undertook this. Secondly, the appointment, for six months, of a project officer was agreed. Those attending the meeting expected that this would lead to the development of an action plan for the implementation of the recommendations of the report but discussion about how this would be achieved – through further investigation or a review of clinical and organisational practice – was not concluded. Funding for the project officer post was identified through the risk management department. It was proposed that a review of progress made by the project officer would be carried out before a final decision was made on whether the Gardai would be informed. The third item agreed was that utilisation of property in Cashel would be explored, in order to address patient mix problems. No minute of the meeting was kept or circulated and no follow-up meeting was arranged. Accounts of the meeting were inconsistent on some points.

22.3.5 A Local Health Manager was appointed on 1 September 2005. Initially he was also responsible for services beyond South Tipperary. He was not present at the meeting on 15 July 2005 but had management responsibility for risk management at the time the September 2004 report was produced and the Regional Risk Manager informed the inquiry team that she had made him aware of the report and its potential implications at that time. She believed that issues of resident safety could not be addressed through risk management, and she recommended further investigation of the findings of the report. Senior nurses and psychiatrists told the inquiry team they were in favour of this. Subsequently, the Local Health Manager, the Assistant National Director, HSE South, PCCC Directorate and the newly appointed Clinical Director agreed to commission a report from an orthopaedic specialist on the September 2004 report, as outlined below. During September the Regional Risk Manager discussed, with some senior managers who attended the meeting on 15 July 2005, the appointment and role of the project officer. However, the post was never implemented and a decision was taken to address the recommendations of the report through local line management. The Local Health Manager informed the inquiry team that he was not aware of the proposal for the project officer post until some time later. Following consultation, it was agreed that it would be more appropriate to develop a respite facility for elderly people in Cashel, rather than transfer residents there from St. Luke's Hospital. A plan to accommodate people with intellectual disability elsewhere in Cashel, through a joint project with a voluntary organisation, had been developed previously and this was implemented.

22.3.6 Although a decision was taken to address the recommendations of the September 2004 report through local line management, no specific group was set up for this purpose and no action plan was developed. The inquiry team was informed that the clinical risk management review group that was set up, as outlined below, did not assume such a role. The Clinical

Director reported to the senior management team on the current situation within the hospital, relevant to the report's recommendations, in May and December 2006. The Clinical Director's reports were descriptive and made no recommendations for further action. Subsequently, the following of the September 2004 report's recommendations, which are outlined in paragraph 22.3.3 above, have been implemented:

- Early in 2006, after taking legal advice, the Local Health Manager requested a written opinion on the September 2004 report, and this was provided by an independent orthopaedic specialist. He was asked "To advise whether the frequency, nature and circumstances of the injuries reported are consistent with the expected occurrence of injuries in a population of this age group and health status" and "To advise if, in your opinion, any of the injuries, in the context within which they occurred, are considered to be non-accidental." The report was not completed until 11 October 2006, over two years after the original September 2004 report. In his October 2006 report the orthopaedic specialist commented that some of the data in the September 2004 report was inconsistent and difficult to evaluate and it was not clear to him that fractures occurred more frequently at St. Luke's Hospital than at similar hospitals. One of the other hospitals appeared to have a similar incidence of injuries. He noted that six of the 19 fractures that occurred during the 18 month period of the analysis were in St. Mary's ward. He reviewed the x rays of five cases and concluded that the injuries were, most likely, caused by simple accidents. He concluded, "There is no substantial evidence, clinical or radiological, in the data made available to me... to point to non accidental injury as a likely or probable cause of the musculo-skeletal injuries that are a feature of the Report". However, he accepted much of the content of the September 2004 report and agreed with its recommendations.

- The acting Director of Nursing carried out a preliminary analysis of injuries and staff rotas. This information was, however, of uncertain value. Many of the injuries occurred some time before an incident report was completed and the rotas were not a reliable record of staff on duty. Members of staff frequently exchanged duties, as rotas were produced several months in advance. The acting Director of Nursing was in favour of an independent investigation, as recommended by the Regional Risk Manager, as he believed this would exonerate nursing staff. The Local Health Manager decided against an independent investigation. He considered that the independent orthopaedic specialist's conclusion, which is quoted in the preceding paragraph, confirmed for him that there was no evidential basis on which to undertake an inquiry as suggested

- A clinical risk management review group has been established and it is responsible for the dissemination of good practice information.

- Risk assessments for falls have been introduced.

The inquiry team was informed that the following developments, relevant to the recommendations of the September 2004 report, took place after its visits in 2007:

- The provision of separate accommodation for residents with intellectual disability has been partly achieved.

- 14 elderly residents moved to long-stay nursing accommodation late in 2008.

22.3.7 When interviewed by the inquiry team, the former Regional Risk Manager expressed concern that, while she did not dispute the findings of the orthopaedic specialist's report, she believed that the nature of some of the fractures was not fully addressed in his report. She raised the possibility of a further report. She provided the Commission with copies of previous correspondence and information on the incidence of injuries at St. Luke's Hospital and St. Michael's Unit, covering the period up to July 2007. The information indicated that about ten to twelve injuries, involving a fracture, occurred each year at St. Luke's Hospital and St. Michael's Unit. Fractures continued to occur as frequently as during the period covered by the 2004 report. Comparison with other hospitals was no longer possible because the local system of data collection had been discontinued in anticipation of a new national system, which was not yet in place. She had continued to inform the Local Health Manager about further injuries to residents in 2006 and 2007 and in a letter, dated 2 May 2007, she had addressed the risk of injury to residents of St. Luke's Hospital and St. Michael's Unit. She stated that during the period covered by the September 2004 report the risk of a resident there sustaining a fracture was between two and three times the average risk of a resident of one of the other psychiatric hospitals in the region. This applied to residents over age 65 and to those under 65.

22.3.8 Residents' accounts indicated that assault by fellow residents was the cause of some injuries. Injuries described in the September 2004 report occurred in almost all wards but it is perhaps not surprising that the highest incidence of fractures in the original report was in St. Mary's ward. The ward accommodated elderly men and women and was permanently locked. The group of residents included some with challenging behaviour and others who were frail and at high risk of falls and fractures.

22.3.9 The inquiry team examined a sample of incident reports and the medical and nursing notes of two of the five residents who had suffered injuries and who were identified in the orthopaedic specialist's October 2006 report. The other three residents were no longer in

hospital. There was insufficient information in the records to allow a definitive conclusion to be drawn regarding non-accidental injury or the quality of care at the time of the injuries.

22.4 Observed risks to residents

22.4.1 Below are extracts from reports on ward visits made by the inquiry team in August 2007 and from the *Report of the Inspector of Mental Health Services 2006 (italics).* They refer to potential causes of injury to, or potentially inadequate supervision of, residents.

22.4.2 St. Michael's ward (male): The corridor flooring was in poor condition with some parts missing and some lifting.

22.4.3 St. Michael's ward (female): On the female side a shower, in the observation area, was in a poor state of repair. It was damp, had no ventilation and water sprayed from the shower onto the floor in the changing area. This created a hazard due to the wet floor.

22.4.4 St. Clare's ward: *"One of the dormitory areas was run down and had an uneven floor that could constitute a hazard..... all three (single) rooms required wardrobes and new flooring."* (see 22.5.9)The floor (of the five bed dormitory) was in need of repair and could present a trip hazard.

22.4.5 St. Paul's ward: *"the floors were uneven and slippy. This was not safe for a patient group who were at high risk of falling."* (see 22.5.9)Staff reported that often only four nurses were on duty. The floors and floor coverings in some of the single rooms were uneven and broken in places, creating a trip hazard. The floor and floor covering in the dining room was uneven and broken in places, creating a trip hazard.

22.4.6 St. Mary's ward: The dormitory areas were situated at both ends of the ward, which had significant implications for care, particularly between 1800-2030hrs, when there were only two nursing staff on duty. A large hole in the flooring in the 'TV room' presented a trip hazard. Many of the floor tiles were beginning to lift at the edges and were becoming trip hazards. There were eight residents with serious mobility problems and many others who were at increased risk of falling. A number of residents used hip protectors.

22.4.7 St. Bridget's ward: The agreed staffing level for the ward was a minimum of four nurses during the day, although five were sometimes allocated, and two at night (2030-0800hrs). Staff reported there were often only three nurses allocated to the ward. On the day of the visit six were rostered but two were allocated to St. Michael's Unit.

22.4.8 St. Kevin's ward: The agreed nursing complement was four during the day and one at night. Nursing staff reported that they were often left with two staff on duty during the day because staff were transferred to other wards. A member of staff was assaulted on the unit a few weeks previously.

22.4.9 St. John's ward: Two residents were on raised levels of observation at the time of the visit.

22.4.10 St. Teresa's ward: Three registered nurses were on duty at the time of the visit, which was the agreed staffing level, but we were told that staff were often taken from the ward to cover shortages elsewhere. There was one bathroom and there were two showers for 21 residents. These were generally clean, although some of the floors were wet at the time of the visit.

22.4.11 In December 2008 the HSE informed the inquiry team that it had 'addressed the stated infrastructural deficits' described in section 22.4.

22.5 Comment

22.5.1 The clinical risk management report on injuries to residents between 2002 and 2004 that resulted in a fracture was dated 3 September 2004. The incidence of fractures affecting residents of St. Luke's Hospital and St. Michael's Unit was significantly above the average for residents of psychiatric hospitals in the region and the types of fracture appeared to be different. The report was unable to identify any common cause for the apparent increase in the risk of injuries from the documents available but it would be clear to any person reading the report that there was a concern about the possibility of inadequate care, or even non-accidental injury. Bearing this in mind, the process that followed lacked appropriate urgency.

22.5.2 The September 2004 report was not considered until nearly a year later by senior managers and clinicians. It is likely that the lack a Clinical Director and the change of service management from Health Boards to the HSE affected this process. At a meeting of senior managers and clinicians on 15 July 2005 the possibility of non-accidental injury and the need for further investigation were discussed. There was no official record of this meeting, its authority was unclear and there was a failure to allocate individual responsibilities, which led to a failure to pursue the agreed actions promptly and effectively. An orthopaedic specialist opinion was sought subsequently but not until the beginning of 2006. The orthopaedic specialist's report was not completed until 11 October 2006, which was over two years after the original report. In view

of the possibility that residents may have been at risk of injury that was non-accidental or the result of poor care, this was an unacceptable delay.

22.5.3 The orthopaedic specialist's opinion was that there was no substantial evidence of non-accidental injury. The inquiry team accepts this. He did not comment specifically on the number of residents with evidence of more than one fracture. This appeared to be greater than would be expected and there have been more cases since 2004. Comparison of this with other hospitals is not possible, however, because the system for collecting this information has been dismantled and replacement by a national system has not yet taken place.

22.5.4 Some of the information in the September 2004 report that compared different hospitals was not easy to interpret. In his October 2006 report, the orthopaedic specialist noted that one hospital had a similar incidence of injuries to that at St. Luke's Hospital and St. Michael's Unit, although the other hospitals had a lower incidence. He believed that more information was required to reach a definite conclusion. However, no further investigation has been carried out. The Regional Risk Manager calculated that, at the time of the September 2004 report, the risk of residents of St. Luke's Hospital or St. Michael's Unit sustaining a fracture was between two and three times higher than the average risk of residents of the other psychiatric hospitals in the region. Although the orthopaedic specialist expressed reservations about the basis for this estimate, it is the best that is currently available. Further investigation would have clarified whether this estimate was accurate, or whether it was too low or too high. The number of residents of St. Luke's Hospital and St. Michael's Unit sustaining fractures each year has not changed substantially since the September 2004 report. Recent data, which would allow comparison between hospitals, is not available, as noted above.

22.5.5 The September 2004 report identified a number of 'risk management issues', such as lack of activity and exercise and the accommodation of frail residents with others who were potentially aggressive, which would be likely to contribute to an increased risk of injury. Several of these 'risk management issues' were the same as concerns that have been identified in the Inspector of Mental Health Services' 2005 and 2006 reports. In section 22.4 above the risks to residents that were observed by members of the inquiry team during its visit to St. Luke's Hospital and St. Michael's Unit are described. Recommendations aimed at addressing the 'risk management issues' were made in the September 2004 report and they were regarded as being 'of importance' by the orthopaedic specialist. These recommendations have not been systematically addressed and several of the recommendations made in our inquiry report repeat those of the September 2004 report. Implementation of the recommendations of the September 2004 report would have required substantial investment in inpatient services, in order to bring them up to a standard that would be equivalent to that outlined in *A Vision for Change*.

22.5.6 Only one of the 19 incidents, involving a fracture, was witnessed by a member of staff. The orthopaedic specialist considered that this raised important questions in relation to ward management procedures. There was insufficient documentary evidence to allow the September 2004 report to reach a conclusion on any common cause of the injuries. The proportion of unwitnessed incidents appeared to be unusually high, although there was no information in the report on the frequency of unwitnessed incidents in other hospitals. No further investigation has been carried out, although it would be expected to throw light on possible causes of the lack of observation, such as staff shortage, unsatisfactory work practices or unsuitable environments. Both the September 2004 report and the orthopaedic specialist's October 2006 report recommended identifying staff on duty at the time of the 19 incidents, although the orthopaedic specialist effectively ruled out non-accidental injury as a likely cause of the injuries. The inquiry team is of the view that this 'cross-matching' could not be done easily or reliably, for reasons given above, and identification of members of staff might still put them in an invidious position. Those members of staff may have been able to provide information on factors contributing to the lack of observation at the time but investigation of more recent incidents would provide more up to date information. The inquiry team does not have up to date information on whether the proportion of injuries to residents that were not observed by a member of staff, at St. Luke's Hospital and St. Michael's Unit, remains as high as that in the September 2004 report.

22.5.7 The inquiry team believes that, where the safety and welfare of residents appears to be at risk, prompt action is required. Further investigation to clarify the level of risk and implementation of measures aimed at reducing the risk is necessary. The inquiry team believes that the lack of urgency of the process following the September 2004 report, the lack of further investigation to clarify the level of risk to residents and the failure to implement many of the report's recommendations indicate that the safety and welfare of residents was not given the highest priority. The inquiry team believes that this was probably influenced by industrial relations problems, a concern to avoid bad publicity and potential distress to relatives. Substantial investment in inpatient services would have been required to carry out the recommendations of the September 2004 report and this would not be attractive at a time when a five year plan, which incorporated hospital closure, was being developed. The inquiry team believes that implementation of the recommendations of our inquiry report should effectively address concerns about residents' safety and welfare and this should not be postponed while any further investigation is carried out.

22.5.8 The establishment of a clinical risk management review group should enable the identification and investigation of serious incidents. There are local policies on the management of serious incidents, such as sexual assault and violence. These were in place in 2004, although the management process that followed the 2004 report was not obviously covered by the

policies. The current lack of an information system to monitor trends in clinical incidents is a cause of concern

22.5.9 It is in the nature of clinical practice that things will go wrong from time to time. At such times, good practice will ensure that the risk has been recognised and considered by the clinical team; the team has made a sensible decision about the management of the risk, recorded this accurately and promptly, and continued to monitor the situation, keeping up to date records of any changes in circumstances or decisions. The comments on risk assessment and clinical recording made in the two clinical risk management reports indicated that good practice in these areas was not always achieved, putting residents and staff at potential risk.

22.5.10 The Report of the Inspector of Mental Health Services 2007 commented, *"The unit had been painted. New flooring, new furniture and new wardrobes had been acquired."* and, *"A 4-bed dormitory was in need of refurbishment. The Inspectorate was informed that this dormitory had been prioritised for closure."* (St. Clare's ward)

The Report of the Inspector of Mental Health Services 2007 commented, *"The unit had been painted. New flooring, new furniture and new wardrobes had been acquired."* and, *"It was reported to the Inspectorate that the new lino had been put down in haste and that it had bubbled up and become uneven."* (St. Paul's ward)

22.6 Findings

22.6 a) A clinical risk management report, dated September 2004, noted that injuries, involving a fracture, sustained by residents of St. Michael's Unit and St. Luke's Hospital between 2002 and 2004 was above the average for residents of psychiatric hospitals in the region and the types of fracture appeared to be different.

22.6 b) That report identified several factors, including lack of activity and exercise and caring for frail and potentially aggressive residents together, that would be likely to increase the risk of injury to residents. Recommendations were made to address these risk factors.

22.6 c) That report was not considered by senior managers and clinicians until nearly a year later, at a meeting that lacked a clear purpose, was not minuted and, largely through a failure to identify those responsible for follow-up, failed to initiate appropriate actions to address the findings and recommendations of the report.

22.6 d) At that meeting the possibility that the injuries were the result of inadequate care or non-accidental injury was acknowledged, as was the need to clarify the findings of the report and implement its recommendations.

22.6 e) In 2006, over two years after the original report, an orthopaedic specialist provided an independent report on these injuries. He considered that more information was required before it could be concluded that injuries occurred more frequently than in the other hospitals. He believed there was no substantial evidence of non-accidental injury and the inquiry team accepts this opinion.

22.6 f) The Regional Risk Manager calculated that, at the time of the September 2004 report, the risk of a resident of St. Luke's Hospital and St. Michael's Unit sustaining a fracture was between two and three times the risk of a resident of one of the other local psychiatric hospitals. There are uncertainties about this figure but it is the only estimate available.

22.6 g) Only one of 19 injuries covered by the September 2004 report was witnessed by a member of staff. The report recommended identifying members of staff on duty at the time of injuries but this could not be readily done through the nurse rostering system. The investigation of recent incidents would provide up to date information on any continuing problems associated with observation.

22.6 h) There has been no further investigation into the matters covered by the September 2004 report. The report's recommendations, which were supported by the orthopaedic specialist, have not been systematically addressed.

22.6 i) During its visits to St. Luke's Hospital and St. Michael's Unit the inquiry team identified environmental hazards and, at times, staff shortages, which put residents at increased risk of injury.

22.6 j) A clinical risk management review group has been established to liaise with clinical risk managers, to monitor clinical risks to residents and to assist the management of risks by senior managers.

22.6 k) Until the national incident reporting database is in place, the investigation of trends in clinical incident reporting will be hindered by a lack of statistical information, which was previously available locally.

22.6 l) Clinical risk management investigations have been impeded by deficiencies in clinical recording.

22.6 m) Taking into account the lack of further investigation following the September 2004 report, the limited implementation of its recommendations and the extreme slowness of the process, the inquiry team considers that the safety and welfare of residents was not given the highest priority.

23. NOTIFICATION OF THE ADMISSION OF CHILDREN

23.1 This section addresses concerns raised about late notification of the admission of children.

23.2 Background and explanation

23.2.1 The Code of Practice relating to Admission of Children under the Mental Health Act 2001 came into effect on 1st November 2006. It was prepared by the Commission in accordance with Section 33(3)(e) of the Mental Health Act 2001, for the guidance of persons working in the mental health services.

23.2.2 Section 2.5(m) of the Code of Practice states, *"The Commission should be notified of all children admitted to approved centres for adults within 24 hours of admission by using the associated Notification Form. Procedures should be in place to identify the person responsible for notifying the Commission."* This section was amended on 6th February 2007 to extend the notification period to within 72 hours of admission.

23.2.3 The inquiry team was informed that the Grade 5 administrative staff member in St. Michael's Unit was the person responsible for notifying the Commission. The inquiry team reviewed admissions of children to St. Michael's Unit and notifications from 1st November 2006 until end of October 2007. During this period 15 children were admitted, including three who were admitted prior to 1st November 2006 and who remained as inpatients when the code of practice came into effect.

23.2.4 Twelve of the admissions were notified within the 72 hour limit set out in the code of practice. The notification of three admissions was delayed by four, seven and 32 days respectively. In one instance the Commission contacted the Grade 5 administrative staff member regarding the delay. The Commission was informed that notification had been forwarded as soon as it had come to the attention of the member of staff and this had resulted in the delay of 32 days. In another instance the form was submitted as soon as it was signed by a consultant psychiatrist and this had resulted in a seven day delay. One admission was notified after four days and this was over the Christmas period.

23.3 Finding

23.3 a) Few notifications failed to meet the requirements of the code of practice, although this was unclear at the outset of the inquiry.

24. FUTURE SERVICE PROVISION

24.1 This section describes local plans for service development and compares these with recommendations from *A Vision for Change*.

24.2 Background

24.2.1 *A Vision for Change* sets out the national policy for the development of mental health services. *The Report of the Inspector of Mental Health Services 2006* made the following recommendations in order that South Tipperary mental health services develop in line with the policy.

- *"All multidisciplinary teams should be fully staffed and have access to adequate day facilities, team headquarters and interview rooms.*

- *A fully staffed rehabilitation team should be appointed as matter of urgency.*

- *Admissions to long-stay wards in St. Luke's Hospital should cease immediately.*

- *All long-stay patients must have a multidisciplinary care plan and access to therapeutic activities that are appropriate to their needs.*

- *A comprehensive mental health service for people with intellectual disability must be provided. In particular dedicated mental health teams should be provided as well as a range of required in-patient and community facilities."*

24.3 Local plans

24.3.1 The inquiry team was provided with documentation that described local planning, which was aimed, initially, at meeting recommendations in *Planning for the Future*. More recent plans have been formulated to meet the recommendations of the Inspector's 2006 report and to achieve service provision in line with *A Vision for Change*. Progress in these areas was discussed at meetings of the inquiry team with health service managers and clinical staff.

24.3.2 The mental health services senior management team had set up a South Tipperary mental health services development group. The group was chaired by the Clinical Director and was made up of consultant psychiatrists, nurse managers, the Hospital Manager and representatives

of professional groups, trade unions and advocacy. In June 2005 the group produced a report, a 'Profile of Service Users In-Patient in St. Luke's Hospital'. The report contained information on the place of origin, age, gender, length of stay and diagnosis of hospital residents. At the time there were 154 residents in St. Luke's Hospital. Almost half of them had been in hospital for ten years and 40 per cent for over 20 years. Almost a third were from North Tipperary and 43 had intellectual disability. The report made recommendations, which were aimed at enabling hospital residents to move to a 12-bed supported accommodation development in Cashel.

24.3.3 In April 2007 a report, 'From Vision to Reality', by the recently appointed CNM3 in rehabilitation and resettlement, referred to the need to bring the 2005 report up to date because of policy changes, especially the hospital closure plan outlined in *A Vision for Change*. The report noted there were 135 residents in St. Luke's Hospital and that, over time, the number of residents was decreasing and the average age of those who remained was increasing. 40 per cent of residents were over 65. The residents had been in hospital, on average, for nearly 15 years. Almost a quarter of the residents came from North Tipperary and 30 residents had intellectual disability, four in association with mental illness. The report outlined four steps that were required to bring about the proposed change from an institution based service to a community service: ending admissions and transfers, assessing the needs of residents, developing appropriate alternative accommodation and resettling the residents. The report identified problem areas that required attention: service provision for North Tipperary residents and recruitment and training to replace nurses near to retirement. Possible accommodation options were discussed and several recommendations were made, including the development of a rehabilitation team and a resettlement team and the development of needs and risk assessments for residents.

24.3.4 In June 2007 the hospital senior management team approved a 'Policy on Access, Assessment, Admission and Discharge' for South Tipperary mental health services, to be implemented by multidisciplinary teams. The policy stated that there should be no admissions to St. Luke's Hospital apart from admissions to respite beds in St. Mary's ward and rehabilitation beds in St. Teresa's ward. In 2005 there were 129 admissions to St. Luke's Hospital and 100 in 2006. In the first six months of 2007 there were nine admissions.

24.3.5 The CNM3 in rehabilitation and resettlement provided a further report, in July 2007, on progress in meeting the recommendations made in 'From Vision to Reality'. Needs assessments, using the *Camberwell Assessment of Need*, had been made for half the residents of St. Clare's ward and for 12 other residents. Agreement had been reached on the use of a risk management tool. Relatives of residents of St. Clare's ward had been informed of the proposed closure of the ward and some meetings were held to provide further information and reassurance. In order to identify placements for residents, meetings were held with nursing home proprietors and other

potential service providers but these were not well attended. A possible problem with accessing funds for nursing home places, using subvention, was noted in the report. The report expressed the hope that places in nursing homes and elsewhere would be found for the residents of St. Clare's ward, so that the ward could close in March 2008. The focus of resettlement would then move to St. Paul's ward. Needs assessments for its residents were to be completed by the end of 2007.

24.3.6 The service development group produced a 'Five Year Plan for the Development of General Adult Mental Health Services in South Tipperary 2006 - 2010', which was approved by the hospital senior management team and the Local Health Manager. The plan identified two priorities. The first was 'Community Development'. Under this heading was the development of community mental health services, including community teams, day hospitals, supported accommodation and specialist services. A change from a service based on three sectors to one based on two sectors was required, as was the development of IT and communication systems. The second priority was 'De-institutionalisation'. This would require the identification of service providers and the agreement with them of a strategy to assess the needs of residents. The five year plan envisaged a service with community places for people with intellectual disability, a resettlement team to support elderly people in the community, highly supported community accommodation for people with mental illness, a medium secure unit and new accommodation for elderly people on the hospital campus.

24.3.7 The plan outlined revenue and capital costs for a five to seven year programme, which would bring about the closure of the five long-stay wards at St. Luke's Hospital and the development of community services in line with *A Vision for Change*. It was noted that additional staff would be required, especially in clinical psychology, social work, occupational therapy, nursing and administration. External support would be required in the management of capital projects and the sale of land would be required to fund the projects. The sourcing and development of appropriate accommodation would also require assistance. Progress on the plan's objectives for 2006 and 2007 has been patchy. Some planning and consultation objectives were achieved. Assessment of residents, to inform discharge plans, was not completed in 2006 but had commenced by the time of the inquiry team visit. The appointment of a consultant psychiatrist and two occupational therapists to the rehabilitation team has been partly achieved and an interim intellectual disability ward has been opened, although a year later than planned. Construction work on the Morton Street Day Centre and the high support accommodation in Clonmel has not been completed, or yet started. Opening of the day hospital in Cashel and reorganisation of sectors has not been achieved.

24.3.8 In July 2007 HSE South indicated that a regional plan for mental health services would be developed as part of a national plan. This would incorporate redrafted local service plans. The

Assistant National Director, HSE South, PCCC Directorate told the inquiry team that HSE South was developing the regional plan and that trade unions and professional organisations would be involved. South Tipperary mental health services were considered to be a priority. Local staff told us they had put considerable time and effort into the development of the five year plan and they felt confused by the latest change.

24.4 Achieving services in line with *A Vision for Change*

24.4.1 There is local agreement that adult mental health services should move to a two sector model, one based in Cashel and a slightly larger one in Clonmel. The 2006 census population of South Tipperary was 83,221, so the sector catchment populations would be smaller than the 50,000 proposed in *A Vision for Change*. A team base, day hospital and high support hostel have been built in Cashel, although the team currently based in Tipperary told the inquiry team that they had some concerns about moving there, as this would reduce the level of service to residents of Tipperary, which is a more deprived community. A community mental health centre, including a base for the Clonmel team and a day hospital are planned on the south-west corner of the St. Luke's Hospital site. The Morton Street Day Centre is to be expanded and developed. HSE South has approved funding for these projects. The existing Clonmel teams have some concerns about whether the team base will be large enough to accommodate the services to be based there. Staffing of the two proposed teams to levels proposed in *A Vision for Change* would require recruitment or redeployment, particularly, but not exclusively, in nursing and occupational therapy.

24.4.2 Adults admitted to St. Michael's Unit come from both North and South Tipperary at present. The North and South Tipperary Local Health Managers have recommended that all mental health services for people from North Tipperary should, in future, be provided from within HSE West. However, plans for this change have yet to be developed. Based on 2006 figures, 65 per cent of admissions to St. Michael's unit were from South Tipperary, requiring the use of about 32 beds. The service model outlined in *A Vision for Change* proposes the provision of 35 mental health admission beds for adults aged 18 to 65 and a crisis house of ten beds for a population of 300,000, together with a 30 bed intensive care rehabilitation unit and 20 places in high support intensive care residences for each region. This would equate, approximately, to a provision of ten admission beds, three crisis beds and nine ICRU beds for South Tipperary, a substantial reduction on current bed numbers.

24.4.3 It is envisaged that the rehabilitation team will have a base in the community mental health centre. St. Teresa's ward will be developed as a rehabilitation ward and the rehabilitation team will take on responsibility for supporting people in local accommodation. The adult sector

teams currently provide this support. Currently there are a total of 28 high support residential places in Cashel and Tipperary, 20 medium support places, some in Clonmel and some in Tipperary, and 33 low support places within South Tipperary. *A Vision for Change* proposes that there should be a rehabilitation team and 30 staffed residential places for a population of 100,000, together with a small number of high support intensive care residences. Although a substantial number of staffed community residential places already exist in South Tipperary many more will be required to accommodate current hospital residents. About 30 day centre places for each catchment area population of 300,000 are recommended, although day centre places already exist in South Tipperary, linked to adult sector teams.

24.4.4 There is currently one child and adolescent community mental health team in South Tipperary. The team is not fully staffed and it provides services for those under 16. *A Vision for Change* proposes one team for a population of 50,000, to provide services for those up to age 18. Admission beds for young people should be available at St. Stephen's Hospital in Cork in the future but the timing of this is unclear. Additional resources will be required for the proposed community and liaison teams and day hospitals.

24.4.5 *A Vision for Change* proposes a community mental health team for the psychiatry of later life for a population of 100,000. Access to, approximately, two admission beds, eight continuing care beds and seven day hospital places is envisaged for a population of the size of South Tipperary. A community team already exists in South Tipperary but it is not fully staffed. At present people are admitted to St. Michael's Unit and there are 23 continuing care beds in St. Mary's ward, although many of the residents there are elderly long-stay residents.

24.4.6 Closure of the long-stay accommodation at St. Luke's Hospital is agreed in principle. The development of community services can only proceed when resources are made available, probably linked to the closure of wards. After a lengthy delay, agreement was reached and the high support hostel in Cashel opened on 3rd December 2007. Following this, residents moved to the hostel from St. Teresa's ward and, following transfers of residents within the hospital, St. Kevin's ward closed and St. Bridget's ward became an interim intellectual disability ward. Eventually, residents from this ward should move to the community placements proposed in the five year plan. At present there is no clear plan for an intellectual disability community team to support them and others with intellectual disability in the community.

24.4.7 The inquiry team was informed that St. Clare's ward closed at the end of 2008, following the transfer of residents to nursing homes.

24.4.8 In January 2008 the HSE announced an implementation plan for *A Vision for Change*. The priorities for 2008/9 were the delivery of catchment area definition and clarification, modernisation of mental health infrastructure; community based mental health teams, child and adolescent mental health services, mental health services for people with intellectual disability and mental health information systems.

24.4.9 In June 2008 the Independent Monitoring Group published its second report on *A Vision for Change,* covering the period from February 2007 to January 2008. The report noted that, since its first report, all parties had embraced *A Vision for Change* as the framework for mental health service development and important first steps had been taken towards the implementation of its recommendations. However, the report expressed concern regarding *"the lack of a systematic approach to implementation and the lack of clarity in responsibility for implementation in the Health Service Executive (HSE)."* The monitoring group was encouraged that the HSE had agreed an implementation plan but considered that the plan lacked detail and focused on short term goals. The report anticipated that a comprehensive HSE plan, addressing all the recommendations of *A Vision for Change*, including those that would take longer to achieve, should be available by the end of 2008. The report expressed several other serious concerns, including a concern that, during 2006/7, *"€24 million of the €51.2 million development funding allocated to the HSE for the implementation of A Vision for Change was not used as planned."* The report made detailed recommendations aimed at accelerating the slow implementation of the recommendations of *A Vision for Change.*

24.5 Comment

24.5.1. In order to address concerns identified in *The Report of the Inspector of Mental Health Services 2006* a number of staffing developments are needed, particularly in St. Luke's Hospital and in the intellectual disability service. Development of community services will also require the appointment of additional staff along with a reduction of admission numbers, which will release some of the staff who are currently engaged in the care of residents.

24.5.2 A number of the objectives of the first two years of the local five year plan have been achieved, although often later than intended. Several important objectives have not been achieved yet, although there has been some progress towards them. At the present rate of progress the plan will take substantially longer than the projected five to seven years to achieve. Substantial development funding for *A Vision for Change* was available to the HSE in 2006 and 2007 but much of this was apparently used to fund the unreformed existing service.

24.5.3 There is acknowledgement in the five year plan of a need for external support in order to achieve some objectives. The inquiry team agrees with this and believes that current management arrangements will need enhancement in order to provide the necessary leadership to take forward the plan, or its successor, both in terms of project management and the development of clinical services.

24.5.4 The inquiry team had difficulty in understanding where decisions were made regarding service development and who had the authority to commit funds for development. The system of accountability was not transparent and uncertainty associated with this hindered local managers in the provision of appropriate leadership.

24.5.5 It is unclear to the inquiry team why HSE South did not begin to develop a regional plan for mental health services at the same time as, rather than 18 months later than, the commencement of the local five year plan. South Tipperary is, apparently, regarded as a priority but at the time of completion of this report, the regional plan was not available, 18 months after its development was announced.

24.5.6 The inquiry team was informed that HSE will engage with trade unions and professional organisations through partnership structures, following the development of a regional plan. This will be crucial, as an industrial relations problem held up the opening of the high support hostel in Cashel for well over a year. Delays in reaching agreement over staffing skill mix and the closure programme for St. Luke's Hospital would delay further the transfer of resources required to develop multidisciplinary community and specialist teams.

24.5.7 The local five year plan includes an estimate of the funding that will be required for its completion, which exceeds the funding that will be released by hospital closure. Capital funding may come from the sale of land or from other resources available to HSE South. Clearly, funding will be more difficult, following recent economic changes and the withdrawal of development funding for 2008 for *A Vision for Change.* Implementation of the local five year plan was due to be completed in 2010-2012 but a detailed HSE implementation plan is not yet available.

24.5.8 The Report of the Inspector of Mental Health Services 2007 identified the following areas for development:

- *"Admissions to St Luke's Hospital must cease.*

- *The transfer of acute and long stay services for North Tipperary to HSE West should be planned and completed in 2008.*

- *The conditions in the hospital must be of a standard that protects the individuals' autonomy and privacy as long as the hospital stays open.*

- *All the community and specialty teams should be staffed to the required level outlined in the national policy document.*

- *All residents with an intellectual disability living in the hospital must be located to more suitable accommodation based on assessed need. They should have access to a specialised mental health team."*

24.6 Findings

24.6 a) 'A Five Year Plan for the Development of General Adult Mental Health Services in South Tipperary (2006-2010)' outlined proposed local service developments, which were intended to lead to the establishment of a service in line with the recommendations of *A Vision for Change.*

24.6 b) Closure of the majority of hospital provision and development of community based services, involving substantial investment, will be required to achieve a service in line with *A Vision for Change.*

24.6 c) Some of the proposed developments have been achieved, including the development of a rehabilitation team and, during the period of the inquiry, establishment of an interim intellectual disability ward. Many others have not been achieved in the proposed timescale.

24.6 d) There was a lack of clarity regarding decision making and funding for service developments.

24.6 e) HSE South indicated, in July 2007 - 18 months after development of the South Tipperary plan - that it intended to incorporate local plans into a regional plan in order to achieve services in line with the recommendations of *A Vision for Change*.

24.6 f) The HSE has indicated its commitment to *A Vision for Change* but existing plans do not envisage early implementation.

24.6 g) Funding may be available from land sales and from ward and hospital closures.

24.6 h) There were areas of disagreement with unions on skill mix and other matters, which will delay service developments, unless they are resolved quickly.

25. RECOMMENDATIONS

HSE South and South Tipperary Mental Health Services

1. Must take immediate steps to ensure compliance with all the minimum requirements set out in Regulations, particularly where this report identifies non-compliance.

2. Must take immediate steps to ensure the use of seclusion complies with Rules and that all possible alternatives are available and are used, with the intention of reducing the use of seclusion to a minimum.

3. Must, within six months, develop and implement a policy, based on clinical risk assessment and including staff training, aimed at minimising unnecessary restriction of freedom of residents, including locking ward doors and requiring nightclothes to be worn during the day.

4. Must make arrangements for essential repairs to be out immediately where the safety of residents is at risk.

5. Must, within six months, review the arrangements for maintenance and repairs at St. Luke's Hospital and St. Michaels Unit and take the necessary steps to ensure that maintenance and repairs are carried out promptly.

6. Should, within three months, draw up an action plan to address the concerns identified in the detailed findings of this report that are not the subject of specific recommendations.

7. Should commission an independent survey of the quality of life of hospital residents, which should take account of the views of residents, relatives, carers and staffs. The survey should identify needs and preferences for activities and living environment and inform an action plan to improve residents' quality of life, promote socially inclusive activities and inform the reprovision of accommodation. The action plan should be prepared within six months, at which time a timetable for implementation should be agreed with the Commission.

8. Should, within six months, develop and commence implementation of clinical governance procedures to monitor the effectiveness of clinical policies, in particular those relating to:

a. Seclusion

b. Restraint

c. Care planning

d. Prescribing

e. Clinical recording

f. Clinical risk management

9. Should, within six months, revise the current five year plan (2006 – 2010), taking into account this report and the quality of life survey, with a timetable for implementation that takes into account what has already been achieved, and including:

a. Appropriate short term improvements to residents' accommodation as identified in the action plan of recommendation 7.

b. Introduction of multidisciplinary, needs based care planning, as required in recommendation 1.

c. Appropriate staffing of multidisciplinary teams

d. Development of appropriate services for people with intellectual disability

e. Development of a comprehensive workforce and training plan

f. Reprovision of current residents' accommodation as identified in the action plan of recommendation 7.

g. Closure of long-stay accommodation in St. Luke's Hospital

10. Should, as part of the five year plan, introduce services, policies and training that will lead to a reduction of admission bed numbers in line with recommendations in *A Vision for Change.* This should be coordinated with the changes identified in recommendation 9.

11. Should:

a. Implement the agreed separation of North and South Tipperary mental health services in collaboration with HSE West

b. Finalise the regional strategic plan for mental health services within three months

c. Identify who will be responsible for strategic leadership of and implementation of the regional strategic plan

d. Set a timetable for implementation of the plan, coordinated with the implementation of the South Tipperary five year plan.

e. Define the roles and responsibilities of individual managers in relation to the implementation of the plan and ensure that managers have sufficient time and support available.

The Mental Health Commission

12. Should make arrangements to monitor and ensure the implementation of the above recommendations.

All times specified are from the date of publication of this report. Action plans and policies should be forwarded to the Mental Health Commission at the specified times.

26. CONCLUSION

26.1 This report sets out the inquiry team's concern that individual, person centred care was not at the heart of the system at St. Luke's Hospital and at St. Michael's Unit, although the first principle identified in *A Vision for Change* is, *"The individual is at the centre of the mental health system. The human rights of individuals with mental health problems must be respected at all times."* Staffing and environmental constraints and outdated practices were the principal causes. It was acknowledged locally that change was necessary but clear leadership and of a shared sense of purpose were lacking.

26.2 The slow pace of change resulted in the continuation of practices that adversely affected the lives of residents, such as unnecessary locking of ward doors in St. Luke's Hospital and unnecessary use of seclusion and the nursing of residents in nightclothes in St. Michael's Unit. A combination of staffing constraints and environmental defects, which appeared to increase the risk of injury to residents, was not effectively addressed. Clearer focus on the individual needs of residents through care planning, risk assessment and activity programmes is required, monitored through an effective clinical governance programme.

26.3 The extent of hospital service provision in South Tipperary has reduced substantially over the past 50 years but, in recent years, change in service provision has been slower than in other areas. Too many long-stay residents remain in inadequate accommodation and the cost of caring for them has contributed to a shortage of funding for staffing developments and modern community services. The locally agreed aim is to move to the provision of a service in line with government policy but the current HSE implementation plan does not set a target date for the achievement of this aim and much of the money provided for the development of services has apparently been spent on funding the unreformed current service. Until services change, residents will continue to lead the impoverished lives described in this report.

26.4 Many of the problems identified in South Tipperary are shared, to some extent, by other hospitals, as is clear from the annual reports of the Inspector of Mental Health Services. The Commission's inquiry into the Central Mental Hospital, like this inquiry, identified a need for the HSE, staff associations and other agencies to work together to support change.

26.5 Changes to the service in South Tipperary are taking place and, during the course of the inquiry, a hostel was opened, a long-stay ward was closed and separate inpatient accommodation was opened for most residents with intellectual disability, after frustrating delays. A significant amount of work has been carried out in preparation for changes that are proposed.

26.6 During the course of the inquiry the inquiry team met many members of staff who were committed to their work. The inquiry inevitably focused on areas where improvements were needed, rather than on areas where practice was in line with recognised standards. The inquiry team wishes to express its thanks to all the residents, members of staff and representatives of organisations, who assisted the team during the course of the inquiry, particularly where requests were made at short notice.

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Appendix 1

ADDRESSEE ONLY

Strictly Private and Confidential

Local Health Manager

St. Luke's Hospital

Western Road

Clonmel

30th July 2007

Re: Inquiry South Tipperary Mental Health Services 2007

Dear

In order to assist the Inquiry Committee in their information gathering I would be grateful if you could forward the following information:

Admissions

- Admission Policy
- Transfer Policy
- Update on Admission Audit Data
- Admission of children policy, procedure, numbers admitted

Care Plan/Assessment

- Policy on care planning and details of how it is currently done and any plans for the future
- Copies of all care plan templates/documentation
- Examples of information given to patients on admission
- Differences in care planning across populations e.g. for over 65 years, rehab

- Copies of any standardised assessments used

Observation/CCTV

- Observation Policy and documentation
- Details on how often differing levels of observation are used and frequency of use
- Seclusion policy/audit information/documentation
- Mechanical restraint policy/audit information/documentation
- Physical Restraint policy/audit information/documentation
- Incident Reporting Policy + examples of templates used.
- CCTV Policy

Staffing

- Staffing Chart-composition of each sector team/WTE's/other commitments/working across teams
- Details of the input of other disciplines into specific units/other commitments outside this
- List of wards with names of the CNMII's responsible for the ward. Details of the nursing structure
- Staffing breakdown –nursing per ward
- Training

Rehab

- Rehab Care Pathway
- Details of any staff dedicated to rehab
- Developments regarding funding the rehab team
- Details of Psychiatry of Later Life Team/Rehab Team and commitment to wards
- Assessment packages

Discharge Planning

- Discharge Policy
- Written documentation regarding discharge planning

Complaints

- Policy/Procedure
- Record of complaints

Advocacy

- Details of advocacy involvement

Information available for patients

Activities

- Details of recreational activities
- Details of therapeutic activities

Patient Mix

- Profile on length of stay, age and gender for each ward

Carers Group

- Information on carers group(s)

Five Year Plan

- Update on latest version of five year plan
- List 2006 update

- List 2007 update
- Current status and any impending developments

Please forward the above information marked **private and confidential** for the attention of Dr. Adrian Lodge, Chair Inquiry Committee, Mental Health Commission, St. Martin's House, Waterloo Road, Dublin 4 by **Friday 10th August 2007.** If you have any queries on this matter please phone Administration Officer, Mental Health Commission .

Yours sincerely

_____

On behalf of Dr. Adrian Lodge

Chair of the Inquiry Committee

Appendix 2

MHC Inquiry into South Tipperary Mental Health Services

The Mental Health Commission has been concerned about mental health services in South Tipperary for some time. Most of the concerns are recorded in the Commission's Annual Reports but Inspectors have raised other concerns.

The main areas of concern are:

- Lack of care plans and therapeutic activities for inpatients
- Continuing admissions to long-stay wards at St Luke's Hospital, where the environment requires upgrading
- Lack of development of community-based care
- Unnecessary use of seclusion and locking of wards
- Failure to develop separate services for people with mental illness and intellectual disability
- High incidence of injuries to patients, mostly unobserved
- Failure to notify MHC of admission of children

The Commission therefore decided, at a meeting held on 26.06.07, to establish an inquiry under Section 55 of the Mental Health Act 2001 to investigate these concerns. The terms of reference of the inquiry are *"To review care and treatment practices in St. Michael's Unit, South Tipperary General Hospital, Clonmel and St. Luke's Hospital, Clonmel, including the quality and planning of care and the use of restraint and seclusion and to report to the Mental Health Commission".*

The inquiry will be conducted by Des McMorrow and Maeve Kenny (Assistant Inspectors of Mental Health Services, Mental Health Commission) and Jamie Malcolm (Nurse Commissioner) and Adrian Lodge (Medical Commissioner) of the Mental Welfare Commission for Scotland, who have been appointed as Assistant Inspectors for the purposes of the inquiry. Adrian Lodge will chair the inquiry team.

The terms of reference agreed by the Commission are those of a general inquiry. Current care and treatment practices will be examined with particular reference to the Mental Health Act and its Regulations. The planning of future care will be assessed against policies and guidance set out in *A Vision for Change* and the Commission's *Quality Framework*. If information is received, during the conduct of the inquiry, which would potentially lead to the criticism of an individual, the Team will consult the Commission regarding the most appropriate action.

The team will visit St. Michael's Unit and St. Luke's Hospital during the weeks beginning 20.08.07 and 8.10.07. After meeting with managers and trade union representatives on 21.08.07 we will visit the wards on 22-24.08.07, obtaining relevant information from the nurse in charge and interviewing patients. During the August visit we will identify individuals we would like to interview during the October visit. Individuals who wish to meet us will also be interviewed in October.

Completion of the inquiry will be dependent on the findings but we hope to complete our report by the end of the year.

Adrian Lodge

Inquiry Chairman

Appendix 3

RESIDENT INTERVIEW: resident's views

Resident name	
Visitor name	**Date of visit**
Hospital	**Ward name**

Environment

	Yes	No	Don't know
1. Is the ward kept clean?	□	□	□
2. Is there natural light and fresh air?	□	□	□
3. Is the ward crowded?	□	□	□
4. Is the ward noisy (e.g. TV, Radio)?	□	□	□

5. Are there effective non-smoking/ smoking areas? □ □ □

6. Is the temperature adequately controlled? □ □ □

Facilities

7. Do you have access to a garden area outside the ward? □ □ □

8. Are private spaces and rooms provided? □ □ □

9. Is there privacy in the toilet and bathroom areas? □ □ □

10. Are there areas reserved for women (and men)? □ □ □

11. Can you make telephone calls easily? □ □ □

12. Can you make and receive calls in private? □ □ □

13. Is your personal property safe and readily available? □ □ □

14. Do you have a list of your property? □ □ □

15. Do you have easy access to your money? □ □ □

16. If needed, are you helped to practice your religion? . □ □ □

17. Have you been given written information about the ward? □ □ □

18. Have you been given information on local advocacy services? □ □ □

19. Have you been given information on advanced statements? □ □ □

20. Are you allowed to make a hot drink for yourself? □ □ □

21. Is there access to drinking water without asking staff? . □ □ □

22. Is there a choice of food at meal times? . □ □ □

23. Is the food of good quality? . □ □ □

Care and treatment

24. Do you have a key worker (named nurse)? . □ □ □

25. Do you have contact with a psychologist? . □ □ □

26. Do you have contact with an occupational therapist? . □ □ □

27. Do you have contact with a social worker? □ □ □

28. Do you know the name of your consultant psychiatrist? . ☐ ☐ ☐

29. Have you been given information about your diagnosis? . ☐ ☐ ☐

30. And about your medication and possible side effects? . ☐ ☐ ☐

Activities

31. Are there activities available for you? ☐ ☐ ☐

32. Are the activities chosen to help your recovery? ☐ ☐ ☐

33. Have staff asked you what you would like to do? ☐ ☐ ☐

34. Can you come and go freely from go out of the ward? ☐ ☐ ☐

35. What did you do yesterday?

36. What are you doing today?

37. What will you do tomorrow?

Support

35. Who do you get most help from in the ward?

Experiences

35.	Do you feel this is the right place for you at present?	□	□	□
36.	Do you feel safe in the ward?	□	□	□
37.	Are you treated with respect?	□	□	□
38.	And your rights respected?	□	□	□

39.	Have you ever been physically restrained here?	□	□	□
40.	Or ever been locked in a room here?	□	□	□
41.	Have you or your belongings ever been searched?	□	□	□
42.	Have your clothes or shoes ever been taken from you?	□	□	□
43.	Have you ever wanted to complain about your care?	□	□	□
44.	Do you know how to make a complaint?	□	□	□
45.	Were you offered help at your Tribunal (if detained)	□	□	□

RESIDENT INTERVIEW: visitor's views

Is there an accessible personal history in the resident's records? (Y/N)	
Does the resident have a care plan? (Y/N)	
When was the care plan last reviewed? (date)	
Is there evidence of care reviews taking place? (Y/N)	
Date of last review	
Are medical health reviews recorded as taking place at least six-monthly? (Y/N)	
When did resident last see doctor? (date)	

Does the resident have a programme of activities? (Y/N)	
If yes - Are activities in the ward/unit? (Y/N)	
Off the ward/unit? (Y/N)	
When did resident last have a holiday from the ward? (date)	

Does the resident have a key worker? (Y/N)	
Does the resident receive any visitors? (Y/N) (comment below)	
Does the resident have an advocate? (Y/N)	
Does the resident have a befriender? (Y/N)	
What is the resident's weekly income? (€)	
Is the resident incapax? (Y/N)	
Is the resident involved in choosing his/her own clothes? (Y/N)	

If detained – start date	
- is she/he aware of rights? (Y/N)	
- was assistance given for Tribunal? (Y/N) (if not - comment below)	
- is treatment authorised by written consent? (Y/N)	
- or by a second opinion (S60)? (Y/N)	

Comments:

Appendix 4

MENTAL HEALTH COMMISSION

WARD VISITS

DATE_____ TIME OF VISIT_____

HOSPITAL_____ WARD NAME_____

FUNCTION (as described by staff)_____

Number of beds – total	
Beds male	
Beds female	
Current number of residents (including on pass or LOA) – total	
Male	
Female	
Detained	
Voluntary	
Wards of court	
Number of detained residents on leave of absence	

Number of voluntary residents on pass	
Number of residents in the ward at time of visit	

Number of residents:	Age: under 18		Admission: under 1 year	
	18 – 24		2 – 4yrs	
	25 – 44		5 – 10yrs	
	45 – 64		10 – 20yrs	
	over 65		over 20yrs	

Number of residents from a minority ethnic group	
Number of residents whose first language is not English	
Is there a policy to facilitate religious/cultural practices? (please obtain a copy)	
Have children ever been admitted? (record names)	
Are there special arrangements for them? (obtain copy of policy or make note)	

Diagnoses of residents (number)	
– intellectual disability	
- dementia	
- mental illness	
- alcohol/substance misuse (primary diagnosis)	

Was the ward door locked at time of visit? (Y/N)	
Is the door locked all the time? (Y/N)	
Is a record of when the door is locked kept? (Y/N) (please verify)	
Is there a policy for locking the door? (Y/N/don't know) (please obtain a copy)	

Is there evidence that residents have individual care plans? (Y/N)	
Are there regular reviews of resident's care plans and treatment? (Y/N)	
How frequent are the reviews? (in months)	
Who participates? Resident Medical Nursing OT SW	

(Please circle) Relative Advocate Other (specify)	
Is there a system to carry out regular physical health reviews? (Y/N)	
How frequent are the health reviews? (in months)	
Are the reviews recorded?	

Number of residents on raised levels of observation	
Is there a policy for searching? (Y/N) (please obtain a copy)	
Are searches appropriately recorded? (Y/N)	

How many residents have been declared incapax?	
Are their regular incapax reviews? (Y/N/Don't Know)	
How frequent are the reviews? (in months)	

Number of detained residents with written consent to treatment	
Number of detained residents with treatment authorised by S60 second opinion	

Is there a record of the staff on duty and in charge?			
Nursing staff on duty at time of visit	Agreed no.	Actual	
Registered nursing staff			
Not registered nursing staff			
Staff who are not part of ward establishment			

Do residents have individualised programmes of activities? (Y/N)	
Who is involved in activities? nurses recreation staff OT staff (please circle) voluntary staff other	
Do activities take place off the ward? (Y/N)	
Do residents have easy access to transport? (Y/N)	
How many residents from the ward have had a holiday in past 12 months?	

Do residents have access to an advocacy service? (Y/N)	
Is there access to a befriender's scheme? (Y/N)	

Is there a private area in the ward for telephone calls (Y/N)	
Is there an information leaflet available for residents? (Y/N) (please obtain a copy)	
Is there an information leaflet for relatives (Y/N) (please obtain copy)	

DESCRIPTION OF WARD

Sleeping arrangements (e.g. dormitory, individual rooms, adequate privacy, please describe)

Personal space (personal storage area lockable by resident?)

Day areas (separate day area, adequate size, enough seats for all residents, effective smoking/non-smoking area, separate dining area, general condition)

Bathroom/toilet areas (privacy, cleanliness, sufficient facilities, male/female appropriate)

Access to food and drink (ability to have hot drinks, beverages, snacks)(is there unrestricted access to drinking water?) (arrangements for safe and nutritious food)

Designated outdoor area (safe garden area, easy access to fresh air)

Area for visiting (adequate visiting areas with appropriate privacy, are there restrictions to visiting times?)

Staffing other than nursing (psychiatrist, medical, access to social work, occupational therapy, psychology, opportunity for referral to specialists e.g. speech and language therapy? Are activity programmes recreational or therapeutic - describe)

General condition of the unit (please give general impression of standard and quality of the environment)

What is the future plan for the ward/unit?

Additional Comments (e.g. how you were received, general attitudes of staff)

Appendix 5

ADDRESSEE ONLY

Strictly Private and Confidential

Local Health Manager-South Tipperary

St. Luke's Hospital

Western Road

Clonmel

19th September 2007

Re: Inquiry South Tipperary Mental Health Services 2007

Dear

I am writing to thank the management team and hospital staff for the assistance we were given during the recent visit of the inquiry team to St Luke's and St Michael's Hospitals.

During the visit we identified further information that we would like to have before our visit in October. We thought it appropriate to make this request to you but it is really directed to the local management team. Some of the information may not be available in written form and we will follow this up in the October interviews, where appropriate.

Staffing: We became aware, during the visit, that there is a serious shortage of nursing staff.

- Can you provide us with information on sickness and absence rates, use of overtime and response to recruitment drives.

- What is the agreed level of staffing for each shift on each ward? (only include students who are part of the establishment)

- What has been the actual level of staffing during the past 3 months?

- Nurses told us they spent a lot of time on non-nursing duties, such as residents' laundry and tasks related to meals. Has there been an audit of this?

- Can you provide details of any Clinical Nurse Specialists working in the hospital?

- Is there a time allocation for Consultants and NCHDs to wards in St Luke's?

Workforce planning: Has there been an analysis, by ward, of the workforce needed to meet residents' needs, including the provision of therapeutic activities? Could you provide any existing local reports? We understand that staff have received training in PSI and behaviour therapy. What plans are there to introduce these into individual care plans?

Management of violence and aggression training: We learned that local trainers will be required to undertake nursing duties instead of providing training and they will probably lose their accreditation. What arrangements will be put in place to replace the existing training?

Is there a policy on the management of aggression? If yes could we have a copy?

Ward equipment and environment: We heard that there are often long delays in obtaining equipment (sphygmomanometer - over one year, curtains - several months) unless it is needed on health and safety grounds. Several wards were in need of redecoration. We would be grateful to have information on the hospital maintenance programme and on any constraints affecting this part of the hospital service.

Hospital reconfiguration: There is a plan to close wards and amalgamate others in the near future but members of staff we spoke to seemed unclear of the short-term arrangements to achieve this. We would be grateful if you could provide us with information on this and on the involvement of ward-based nursing staff in the planning.

Clinical Governance:

- In view of the pressure on beds in St Michael's Unit, is there any guidance or peer review relating to admission criteria?

- Is there any expectation or guidance relating to regular psychiatric review of residents in the wards in St Luke's Hospital?

- Is there any contribution by pharmacists or good practice guidance in relation to prescribing? Has there been a recent audit of prescribing?

- Is there systematic monitoring of the use of seclusion?

- Is there any audit or peer review of serious incidents?

- Is there a system of learning from serious incidents?

We received a clinical risk management report entitled "Aggregate Root Cause Analysis of Fractures Recorded July 2002 to 31st January 2004 in St Luke's Hospital, Clonmel, Co Tipperary."

The report is not signed or dated, could we have an update on the recommendations made in this report.

Length of stay: You provided us with information on length of stay for each ward but we believe that some of the information relates to length of stay in hospital and some to length of stay in individual wards. We would be grateful if you could check this for us. It is the length of stay in hospital that we would like.

History of St Luke's and St Michael's: We would be grateful if you could provide us with a brief history of the hospital, if this is readily available.

St Bridget's ward: We would be interested to know the outcome of two problems relating to individuals. Concern was expressed to us about the proposed transfer of a woman from St Michael's ward, although all transfers to the ward should have stopped. Another concern we heard related to the lack of progress in discharging a resident to a place in the community that was apparently appropriate.

We would appreciate if this information could be made available to us on the 8th October, when we next visit the hospital.

Yours sincerely,

_____

Adrian Lodge

Inquiry Chairman

Appendix 6

Mental Health Commission

Inquiry Team

Process Document for Interviews

1. INTRODUCTION

1.1 The Mental Health Commission has been concerned about mental health services in South Tipperary for some time. Most of the concerns are recorded in the Commission's Annual Reports.

The main areas of concern are:

- Lack of care plans and therapeutic activities for inpatients
- Continuing admissions to long-stay wards at St Luke's Hospital, where the environment requires upgrading
- Lack of development of community-based care
- Unnecessary use of seclusion and locking of wards
- Failure to develop separate services for people with mental illness and intellectual disability
- High incidence of injuries to patients, mostly unobserved

- Failure to notify MHC of admission of children

1.2 The Commission therefore decided, at a meeting held on 26.06.07, to establish an inquiry under Section 55 of the Mental Health Act 2001 to investigate these concerns. The terms of reference of the inquiry are *"To review care and treatment practices in St. Michael's Unit, South Tipperary General Hospital, Clonmel and St. Luke's Hospital, Clonmel, including the quality and planning of care and the use of restraint and seclusion and to report to the Mental Health Commission".*

1.3 The inquiry will be conducted by

- Des McMorrow and Maeve Kenny (Assistant Inspectors of Mental Health Services, Mental Health Commission)

- Jamie Malcolm (Nurse Commissioner) and Dr. Adrian Lodge (Medical Commissioner) of the Mental Welfare Commission for Scotland, who have been appointed as Assistant Inspectors for the purposes of the inquiry. Dr. Adrian Lodge will chair the inquiry team.

1.4 The terms of reference agreed by the Commission are those of a general inquiry. Current care and treatment practices will be examined with particular reference to the Mental Health Act and its Regulations. The planning of future care will be assessed against policies and guidance set out in *A Vision for Change* and the Commission's *Quality Framework*. The Inquiry Team aims to carry out the inquiry under normally accepted standards of fairness, with due regard to the preservation of privacy and confidentiality, unless necessary to fulfill our legal and professional requirements.

Completion of the inquiry will be dependent on the findings. The Inquiry Team intends to produce a draft report by the end of the year. After any factual correction, as described below, the final report will be submitted to the Mental Health Commission.

2. INTERVIEWS

2.1 Interviewees will be informed in advance of the meetings regarding the terms of reference and statutory basis for the inquiry.

2.2 The Inquiry Team will provide the interviewee with an opportunity to review and discuss this process document at the start of each meeting, prior to the interview.

2.3 The Inquiry team expects to conduct interviews without interviewees being legally represented. A friend, colleague or advocacy worker, if they wish, may accompany interviewees. Wherever possible at least two members of the Inquiry Team will attend interviews. A written record of the interview will be kept. Interviewees will be given the opportunity to comment on the Inquiry Team's record of their interview. Records will be stored securely and retained by the Mental Health Commission.

2.4 If information is received, during the conduct of the inquiry, which could potentially lead to the criticism of an individual, the Inquiry Team will consult the Mental Health Commission regarding the most appropriate action to take. In these circumstances the principles of natural justice and due process will be afforded.

2.5 The interviews will involve investigation into the actions of key professionals and consequently may involve criticism of practice. The primary purpose of the inquiry is to identify possible improvements to the care and treatment of residents and to make recommendations as to how these can be implemented. Apportioning blame is not the primary purpose. The Inquiry Team is not a disciplinary body - professional negligence and misconduct are matters for employers, courts and regulatory bodies.

2.6 In investigating possible deficiency in care and treatment, the Inquiry Team will take account of the level of resources and provision of services as well as the actions of individuals. It will have regard to good practice guidance, such as the Regulations for Approved Centres 2006,

2.7 The Inquiry Team may consider written statements where appropriate.

3. PROCESSING THE RESULTS OF THE INQUIRY

3.1 The Inquiry Team will provide a draft report to the LHM and the Senior Management Team for factual correction.

3.2 When the Inquiry Team are satisfied that the facts have been established a completed report will be made to the Mental Health Commission. It will be the responsibility of the Commission to decide on the course of action to be taken as a result of the inquiry.

3.1 It is expected that the findings and recommendations will become public and disclosure under the Freedom of Information (Amendment) Act 2003 may be requested, although personal information would be exempt.

Appendix 7 Mental Health Commission (2006) *Quality Framework for Mental Health Services in Ireland.* Dublin: Mental Health Commission.

Appendix 7

Implementation of Standards in 2007			
Number	**Standards**	**Commence**	**Completion by** [to be decided in consultation with stakeholders]
1.1	Each service user has an individual care and treatment plan that describes the level of support and treatment required in line with his/her needs and is co-ordinated by a designated member of the multidisciplinary team	✓	
1.3	Each service user receives mental health care and treatment from a community based service that addresses the persons changing needs at various stages in the course of the his/her illness and recovery process	✓	
1.5	Therapeutic services and programmes to address the needs of service users are provided.	✓	
2.1	Service users receive services in a manner that respects and acknowledges their specific values, beliefs and experiences	✓	
2.2	Service users rights are respected and upheld	✓	
3.1	Service users are facilitated to be actively involved in their own care and treatment through the provision of information	✓	
3.2	Service users are empowered regarding their own care and treatment by exercising choice, rights and informed consent	✓	
3.3	Peer support/advocacy is available to service users	✓	
4.1	Service users receive care and treatment in settings that are safe, and that respect the person's right to dignity and privacy	✓	
4.2	Service users in residential or day settings receive a well-balanced nutritious diet	✓	
6.1	Families, parents and carers are empowered as team members receiving information, advice and support as appropriate	✓	
7.3	Learning and using proven quality and safety methods underpins the delivery of a mental health service	✓	
8.1	The mental health services is delivered in accordance with evidence-based codes of practice, policies and protocols	✓	
8.3	Corporate governance underpins the management and delivery of the mental health service	✓	

Table 1 - Implementation of Standards in 2007

Appendix 8

	Residents views	**St Luke's** (25)		**St Michael's** (6)		**Total** (31)	
		Y	**N**	**Y**	**N**	**Y**	**N**
	Environment						
1	Is the ward kept clean?	21	4	6	0	27	4
2	Is there natural light and fresh air?	21	4	3	3	24	7
3	Is the ward crowded?	10	15	1	5	11	20
4	Is the ward noisy (e.g. TV, radio)?	18	7	3	3	21	10
5	Are there effective non-smoking/smoking areas?	15	7	4	2	19	9
6	Is the temperature adequately controlled?	13	11	4	1	17	12

	Residents views	St Luke's (25)		St Michael's (6)		Total (31)	
		Y	N	Y	N	Y	N
	Facilities						
7	Do you have access to a garden area outside the ward?	19	5	3	3	22	8
8	Are private spaces and rooms provided?	13	11	2	4	15	15
9	Is there privacy in the toilet and bathroom areas?	15	8	5	1	20	9
10	Are there areas reserved for women (and men)?	10	0	3	2	13	2
11	Can you make telephone calls easily?	20	3	5	1	25	4
12	Can you make and receive calls in private?	19	5	3	3	22	8
13	Is your personal property safe and readily available?	17	7	4	2	21	9
14	Do you have a list of your property?	7	14	2	4	9	18
15	Do you have easy access to your money?	20	3	5	1	25	4
16	If needed, are you helped to practice your religion?	21	2	6	0	27	2
17	Have you been given written information about the ward?	0	23	3	3	3	26
18	Have you been given information on local advocacy services?	8	16	3	3	11	19
19	Have you been given information on advanced statements?	0	6	0	1	0	7
20	Are you allowed to make a hot drink for yourself?	3	21	0	5	3	26
21	Is there access to drinking water without asking staff?	17	7	6	0	23	7
22	Is there a choice of food at meal times?	16	7	1	5	17	12
23	Is the food of good quality?	15	8	3	3	18	11

	Residents views	St Luke's (25)		St Michael's (6)		Total (31)	
		Y	N	Y	N	Y	N
	Care and treatment						
24	Do you have a key worker (named nurse)?	6	16	3	3	9	19
25	Do you have contact with a psychologist?	4	19	1	4	5	23
26	Do you have contact with an occupational therapist?	6	17	0	6	6	23
27	Do you have contact with a social worker?	3	20	2	4	5	24
28	Do you know the name of your consultant psychiatrist?	20	4	6	0	26	4
29	Have you been given information about your diagnosis?	8	16	6	0	14	16
30	And about your medication and possible side effects?	8	16	5	1	13	17

	Residents views	St Luke's (25)		St Michael's (6)		Total (31)	
		Y	N	Y	N	Y	N
	Activities						
31	Are there activities available for you?	8	14	1	5	9	19
32	Are the activities chosen to help your recovery?	6	11	1	4	7	15
33	Have staff asked you what you would like to do?	7	16	1	5	8	21
34	Can you come and go freely from the ward?	16	7	1	5	17	12

	Residents views	**St Luke's** (25)		**St Michael's** (6)		**Total** (31)	
		Y	**N**	**Y**	**N**	**Y**	**N**
	Experiences						
35	Do you feel this is the right place for you at present?	11	12	4	2	15	14
36	Do you feel safe in this ward?	18	5	5	0	23	5
37	Are you treated with respect?	19	1	6	0	25	1
38	Has anyone explained your rights to you?	9	11	1	5	10	16
39	Have you ever been physically restrained here?	6	17	2	4	8	21
40	Or ever been locked in a room here?	10	12	1	5	11	17
41	Have you or your belongings ever been searched?	1	21	3	3	4	24
42	Have your clothes or shoes ever been taken away from you?	4	17	5	1	9	18
43	Have you ever wanted to complain about your care?	9	14	3	2	12	16