

**Cappahard Lodge
Residential Centre
Clare Mental Health Services
Ennis Co. Clare.**

Independent Review of Policies and Procedures

October 2008

	Contents	Page
Section 1	Introduction	4
Section 2	Methodology	8
Section 3	Management arrangements and development of services	11
Section 4	General comments on good care and areas for improvement	16
Section 5	Review of Policies and Procedures	24
	General issue: framework for policies	24
	Admissions to Cappahard lodge	26
	Identification of residents	29
	Privacy & dignity	30
	Resident's personal property	35
	Management of residents' funds	36
	Assessment and care planning	37
	General health care	40
	Management of challenging behaviour	46
	Falls	49
	Absconding	50
	Response to medical emergencies	51
	Prescribing and administration of medication	52
	Food and nutrition	55
	Recreational and therapeutic activity	55
	Palliative care	58
	Sudden death policy	60
	Record keeping	61
	Religion policy	62
	Visiting	63
	Key relative	65
	Complaints	67
	Abuse	71
	Staffing policies	73
	The use of close circuit TV	77
	Correspondence and communications	79
	Food safety policy	80
	Health and safety and risk management policies	81
	Legal status of residents	82
Section 6	Summary of conclusions and recommendations	84

Chairperson's Acknowledgements

As Chairperson of the Independent Review Committee I would like to place on the record my thanks to my colleagues, Mr P.J.Lawlor and Mr Tom O'Dwyer for their hard work and commitment during the review.

I wish to express my appreciation to the management and staff of Cappahard Lodge who attended for interview. A number of relatives of the residents in Cappahard also attended for interview and our grateful appreciation is extended to them for taking the time and effort to attend and be of such assistance to our work.

I acknowledge the cooperation of all those interviewed and their timely response and return of completed interview transcripts. I am also most grateful to those members of management and staff and others interviewed who provided additional documentation for the information of the committee.

I wish to formally acknowledge the support of the management of HSE West who facilitated the work of the committee and who provided all necessary information and documentation in a timely fashion.

Finally on behalf of the Independent Review Committee I wish to record our sincere thanks and gratitude to Ms Geraldine Crowe, secretary whose hard work and attention to detail greatly facilitated the work of the committee.

Donald Lyons

Chair of Review Committee

Cappahard Lodge

Section 1: Introduction

Cappahard Lodge is a residential facility operating under the Clare Mental Health Service for Older Persons. The centre was a purpose built nursing home and was purchased and refurbished by the former Mid Western Health Board in 2002 as part of the process to facilitate the closure of Our Lady's Psychiatric Hospital in Ennis. It is a single-story facility on the outskirts of Ennis with two enclosed garden areas and a large landscaped site. In recent years the area has seen significant surrounding residential developments.

Our Lady's Hospital closed fully in March 2002 with the relocation of hospital based patients and staff to a broad range of alternative community facilities in County Clare based on the care continuum. 46 long stay inpatients from St. Mary's (Female) and St. Flannan's (Male) wards were discharged under the Mental Health Act (1945) to Cappahard Lodge.

Bed capacity at Cappahard Lodge has reduced since it opened in 2002 with 46 residents and the current agreed bed capacity is 35 including 31 continuing care beds and 4 respite care beds. Current unit population is mixed and it continues to cater for persons with specialist dementia care needs and persons with functional mental illness as well as providing 4 respite care beds for community based clients.

The current diagnostic composition is as follows:

Table 1: Current Diagnostic Composition

Beds	Number	Percentage
Depressive Illness	3	9 %
Dementia	9	28 %
Other Psychiatric	15	46 %
Intellectual Disability	6	19 %
Current Vacancies	3	
Respite Beds	4	

23 current residents were former residents of Our Lady's hospital.

The main building accommodates the 35-bedded residential area and also office accommodation for the Clare Mental Health Services for Older Persons (CMHSOP) and Community Rehabilitation Teams. A linen storage facility is also accommodated at the centre together with a laundry production facility in a separate building on the campus.

Context of Policy Review

In May 2007, the HSE West established the review committee following a directive from the Assistant Director of the PCCC. After some discussion, the remit of the committee was agreed in July 2007. It was agreed that the committee would review policies and procedures in Cappahard Lodge. There had been concerns arising from a complaint about the care of one resident and concern from a staff member about work practices in mental health facilities in Clare including Cappahard Lodge. Both of these issues are being examined by the HSE in accordance with the usual procedures.

The Review of policies and procedures which is the focus of this report does not deal specifically with these or any complaints but rather examines the overall issue of adequacy of the policies in existence or otherwise and the extent to which actual practice on the ground adheres to such policies. While we have not dealt with the specifics of these cases, we have taken note of the general issues arising from them in conducting our review.

The Committee established that the focus of the review was neither judicial nor disciplinary in relation to any individual member of HSE staff. It was a general review with the focus on learning for the future and the assurance that all policies would be updated and practice reviewed to ensure full accordance with best practice and quality standards.

The Committee was guided in its process by a Draft Manual for the conduct of investigations in the PCCC Service.

We have, to the best of our ability, identified positive aspects of the care of residents of Cappahard Lodge and opportunities for improvement. We have made several recommendations that we believe will improve care and reduce risk. We cannot guarantee that we have anticipated every possible scenario. No matter how well governed services are, there will always be a potential for adverse incidents.

The Terms of Reference for the review as set out by HSE West are as follows:

1. Identify and collate all policies and procedures relating to patient care in Cappahard Lodge

2. Examine the extent to which current Policies and Procedures are adhered to.
3. Examine the adequacy of current Policies and Procedures.
4. Make recommendations as to how Policies and Procedures might be improved and/or more appropriately implemented.

The independent committee appointed to carry out this review comprised:

Dr Donald Lyons, Director, Mental Welfare Commission, Scotland

Mr P.J. Lawlor, Director of Nursing, HSE Mid Leinster

Mr Tom O'Dwyer, Management Consultant and former Deputy CEO, Southern Health Board

Ms Geraldine Crowe acted as secretary to the committee.

Section 2: Methodology

2.1 Introduction

This section outlines the methodology used in this review. It is divided into three sections:

1. Preparation Stage: Discusses how the Committee prepared itself to undertake the work at hand.
2. Review of Policies and Procedures: Describes the processes utilised by the Committee during the review especially in relation to the use of interviews and other information sources.
3. Analysis and Report Writing. Outlines the methods used to compile the report.

2.2 Preparation Stage

The Independent Review Committee (hereafter referred to in this report as the Committee) was commissioned on 28th May 2007 by Dr A. Hogan Acting Local Health Manager, Health Service Executive West. The Committee sought copies of all existing policies in place in Cappahard Lodge and held its first meeting on 25th July 2007.

These documents were subsequently reviewed in a uniform and structured way by the individual members of the Committee and later by the full Committee in formal session.

A total of 42 Policy Documents were presented to the Committee. During this preparatory stage the Committee became aware of an initiative by the HSE to establish uniform policy documents on foot of the Regulations issued by the Mental Health Commission governing Approved Centres. Also at this time the Health Information and Quality Association issued draft guidelines for standards in residential services for older persons. The Committee asked the Area Executive if they intended to review their policy documents on foot of these developments. The Area Executive advised that the centre was not yet an approved centre under the Mental Health Act but that it was likely that an application would be made to that effect and that therefore the HIQA standards would not apply. The HSE subsequently applied for Approved Centre status. We understand that application was refused on this occasion because the unit did not comply with many of the approved centre policy requirements. Regardless of the final decision on approved

status, we believe that both sets of policy requirements provide a framework for local policy development to support the care of residents of Cappahard Lodge.

2.3 Review of Policies and Procedures

Arising from the desktop review of policies as presented by the management of the service the Committee drew up a range of topics and questions to seek clarification on the documentation and to determine the extent to which the policies are adhered to in practice.

The Committee was given a significant amount and range of documentation at the beginning of the process and over the period of the review. The committee also received submissions from a Consultant Psychiatrist, a relative (two submissions) and extensive documentation from the Area Executive. It was explained to all that the committee could examine submissions only from the perspective of the Terms of Reference and therefore would examine the general issues arising but would not be in a position to deal with any aspect of a specific complaint if so outlined. The committee noted that specific complaints were the subject of examination by the HSE under separate processes.

The Committee undertook a total of 11 individual or group interviews in Ennis during January and February 2008. Members of staff were interviewed and the Management Team was interviewed on two occasions. The Committee also interviewed relatives of residents in the centre. We selected relatives of five residents at random but also representing relatives with specified clinical presentations to give a comprehensive overview.

We advised all interviewees beforehand that they could be accompanied by a friend or colleague at their meeting with the Committee. All interviewees were also advised that interviews would be recorded to ensure accuracy. After the interview, they were given copies of their transcripts with the facility to listen to the tape in advance of signing the transcript. The signed transcript is the official record of the interview and is utilised only for the purposes of the review.

We visited Cappahard Lodge on four occasions and met management, staff and residents. One visit was conducted in the late evening in order to meet night staff. One of the visits was conducted at short notice by a member of the review committee. The Committee examined the facility and services and assessed both from the perspective of adherence to policies and recognised good practice.

The Committee also arranged for a staff questionnaire to be completed on a confidential basis and 18 completed questionnaires were returned to the Committee.

2.4 Analysis and Report Writing

The analysis and report writing was undertaken by the committee on completion of site visits, all interviews and on the basis of the returned signed transcripts, all documentation received including submissions and completed questionnaires.

The review of policies and procedures undertaken by the Committee is on the basis of a standardised approach to the policy documents presented to the committee. The review examines the policies initially from the perspective of adequacy. Where improvements are considered necessary these are specifically identified. In a small number of cases, a policy does not exist. In any such case the Committee recommends that a new policy be drawn up without delay. The service was also reviewed from the perspective of adherence to the Policies as presented to the committee. The framework used to determine adequacy and adherence included an assessment of the written policies, review of evidence from staff questionnaires, review of interviews, visits to the centre and review of case notes as appropriate.

Arising from the review, a number of recommendations are drawn up to improve the availability of appropriate policies and procedures to govern the service for the future and as a basis on which to quality assure best practice in Cappahard Lodge for the benefit of its residents.

Section 3: Management Arrangements and Development of Services

3.1 Management Arrangements

This section is based primarily on a submission received from the Area Executive of the Clare Mental Health Services.

Management Structure – Care Group Level

The Clare Mental Health Service (CMHS) is part of the Clare Local Health Management (LHM) Primary, Community and Continuing Care (PCCC) Administrative Area (HSE West).

In the CMHS a triumvirate model of Area Executive has been in place since the 1980s. Executive membership is comprised of Clinical Director (Chairperson), Director of Nursing and Area Manager. Executive members reporting relationships are to General Manager and Local Health Manager Clare PCCC Administration Area. Area Executive has overall responsibility for the day-to-day management and development of the CMHS in line with established policy and resource allocation.

3.2 Management of Cappahard Lodge

The committee was advised of the following day to day management arrangements at Cappahard Lodge

Unit staff work as part of the Clare Mental Health Service Older People's (CMHSOP) Team under the clinical leadership of the Consultant Psychiatrist in Old Age Psychiatry. The Consultant is responsible for the provision of specialist care for the residents' mental health needs. As the residents are discharged to a community setting, they have access to General Practitioner services to meet their physical care needs. The Assistant Director of Nursing CMHSOP has overall management responsibility for day-to-day nursing activities.

There is no dedicated administrative/management function on-site at Cappahard Lodge. A Clerical Officer attached to the CMHSOP provides secretarial support. The Area Manager's Department continues to be responsible for the management of resident's pension payments,

and private monies while unit nursing staff manage resident's pocket monies at unit level. This arrangement is in line with agreement reached when the unit was opened in 2002. In line with the National Financial Regulations the LHM Clare PCCC Administrative Area is designated as the Budget Owner for all PCCC services provided within the area, including the CMHS. The co-ordinating role for the management of implementation of HSE budgetary policy within the CMHS care group, including Cappahard Lodge, is carried out by the Area Manager and feedback is channelled to staff through the line management structure. The main daily external HSE services provided to the unit include catering (St. Joseph's Hospital Central Catering facility), laundry and maintenance.

3.3 Staffing at Cappahard Lodge

The committee was advised of the following arrangements for staffing at Cappahard Lodge.

The Staff at Cappahard Lodge are comprised of a dedicated team of registered psychiatric nurses, student nurses and attendant staff. Total dedicated Nursing WTE complement for the unit is 29.74, which include an element of inbuilt replacement cover, and to meet on-going roster shortages due to vacant substantive posts and leave cover. The necessary additional replacement nursing staffs is drawn from a Central Nursing Relief Pool. The Assistant Director of Nursing, (CMHSOP) fulfils the role of Nursing Co-ordinator for the unit.

The agreed daily nursing complement (including 2 CNM II) is 8 and 4 for night duty. Of the two CNM IIs on duty each day, one CNM II is assigned to female functional sub unit and one to male functional sub unit. CNM I attached to unit has a remit for co-ordinating the organisation of residents activation programme

Dedicated Attendant WTE complement for Unit is 7 and includes the in-built replacement cover. Necessary additional replacement staff is drawn from a Central Attendant Relief Pool. There is an agreed daily unit complement of 4 Attendants each working from 08 00 and 19 00 hrs. Attendant duties are divided between catering and housekeeping and work practice is in line with unit specific Food Safety Manual (HACCP) that is based on NSAI IS:340:2007 & IS:22000:2005.. Line management reporting relationship for attendant grade is to Domestic Supervisors but they are also responsible to duty CNM II as unit manager.

3.4 Budget Arrangements

The CMHS's receives an annual budget to deliver existing service with additional funding obtained separately for new developments. Health & Safety, Minor Capital and Mental Health Development allocations are also made available annually. The annual Revenue Budget for Cappahard Lodge is built around the two major expenditure categories of pay and non-pay and not only includes the residential area but the Community Rehabilitation MDT and a Laundry facility which are accommodated on site.

In 2007 the CMHS Revenue Expenditure was 26,441,397 euros of which the pay budget was 22,651,694 euros. Cappahard Lodge's Net Budget was 2,993,584 euros (Pay 2,756,866 euros, Non-Pay 236,718 euros includes Rehab Team and laundry).

3.5 Development of the Cappahard Lodge Services

The committee was advised that since the closure of Our Lady's Hospital in 2002 when services, patients and staff transferred to alternative community facilities a number of initiatives/works have been undertaken in an effort to advance and agree a strategic plan for Cappahard Lodge or as part of the CMHS overall plan. These include:

- In 2002 the Area Executive appointed a Project Group to look at options to ensure an effective and patient focused delivery of mental health services in Clare having regard to accessibility and equability.
- In 2003 a Working Group was established with a remit to assess the needs of the existing population and potential graduates into the future and to explore how existing resources can be best utilized to develop services for the psychogeriatrics and graduates of the catchment area.
- In late 2003 a Draft Proposal for the Development of the CMHSOP was also completed.
- A CMHS Leadership Group facilitated by change management consultants from South London and Maudsley Trust (SlaM) was established in 2005 and has since 2006 being involved in the drawing up of an Agreed Action Plan for the CMHS, including the CMHSOP which incorporates Cappahard Lodge, to meet the requirements of Vision for Change.

- From June to August 2007 monthly meetings were held regarding Cappahard Lodge in an effort to agree the future direction of unit.

Despite this, we note large amounts of correspondence regarding the purpose and function of the unit stretching back over several years. It appears to us that there was a lack of a shared vision as to the purpose and function of the unit.

The committee was also advised that:

The purchase and initial refurbishment of Cappahard Lodge was completed in 2002. Since Cappahard Lodge opened, there has been on-going investment to enhance the physical environment and ensure compliance with statutory and regulatory requirements. Up to the end of 2007 approximately €700K has been expended in respect of Cappahard and included upgrading of flooring, painting, provision of alarms, furniture etc. €78K was expended in 2006 to upgrade heating system while also in 2006 the production laundry that was accommodated in main building was relocated to a separate on-site building. In 2007 a Development Control Plan was drawn up for the Cappahard Lodge Campus and when Mental Health Development Monies of €238K were approved for the CMHS in the same year bathroom and shower area refurbishment works at Cappahard Lodge were prioritized at a total estimated cost of €262K.

The committee was further advised that ongoing works continued in 2008. In February 2008 a Cappahard Lodge Accommodation Review Committee was established, and bed capacity was reduced to 35 beds (31 single and 2 double rooms) to further reduce the patient: nursing ratios. Priority works identified include additional site works from 2007 refurbishment programme and provision of additional storage (linen/equipment). Necessary funding of €57K was secured and works are currently under completion. Refurbishment continues including the provision of window blinds and additional storage. Works also identified include provision of canopy at front door, removal of counter/reception and provision of furniture and further development of the garden. All proposed works are determined and carried out on a fully inclusive consultative basis with staff and relevant professionals.

3.6 Cappahard Lodge – The Future

The Area Executive of the CMHS reiterates their commitment to the agreed future development of Cappahard Lodge. Their aim is to achieve a person centred, efficient, effective and quality

caring environment for the service user and an enhanced working environment for all staff. This would be achieved by working in partnership with residents, carers, families, staff and the statutory and voluntary sectors. Services will continue to be reviewed at Cappahard Lodge as part of the on-going review and development of the CMHSOP within the planned overall development of the CMHS in line with Vision for Change (2006) and all other statutory and regulatory requirements, including the Mental Health Act (2001), in the event of recently submitted Approved Centre Status application being applied to Cappahard. All necessary policies, procedures and protocols will continue to be developed to enhance and ensure compliance in all areas. It is acknowledged that the future is increasingly challenged by new ideas such as new skill mixes to include Health Care Assistants and influences, which will inform future healthcare service delivery at Cappahard Lodge. In an era of demographic change and HSE cost containment, the Executive are aware of the challenge of securing the necessary human and financial resources to realise the full potential of Cappahard Lodge for the betterment of all its stakeholders.

The committee note that the admission policy changed in 2005 to shift the focus from continuing care to the provision of 24 hour specialist care for:

1. Older people with a dementia disorder complicated by severe behavioural and psychological symptoms of dementia (BPSD)
2. Older people with a chronic severe functional psychiatric disorder that is characterised by severe behavioural problems or an unstable fluctuating course.
3. Respite care for such patients.
4. Acute assessment and management for patients with dementia.

3.7 Our commentary on future plans

From our interviews with various individuals and from reading documentation provided to us, we found significant disagreement about the purpose of Cappahard Lodge. The Area Executive considers that the unit must provide care for people with a range of mental health problems. Responses from staff to this was variable. Some staff do not see the present mix of residents as a problem. Others, notably the Consultant, Assistant Director of Nursing and some Clinical Nurse Managers wished the unit to specialise more in dementia care. However, there are three problems with this:

1. Cappahard Lodge is still home to a large cohort of people with chronic functional mental illness who were transferred from Our Lady's Hospital and for whom there is no present identified alternative facility
2. There is a need for continuing care for a small group of older people who develop severe and enduring mental illness. Again, Cappahard Lodge appears to be the only facility available to meet this need.
3. Vision for Change envisages 30 places for older people with mental health problems for 300,000 population. For the Clare catchment population, this would mean 13 places. This would not be enough to make Cappahard Lodge viable as a dementia-only facility for the current population of its catchment area.

We understand the perspectives of all parties here. There is a tension between providing a local service to people with a broad range of illnesses, versus providing dedicated facilities on a regional basis for individual care groups. If Cappahard Lodge became a specialist dementia care facility, it would need to serve a larger catchment population than it does at present. This would need a major strategic examination at regional level by the HSE.

For the foreseeable future, we believe that the unit will continue to serve a mixed client group. We urge all parties to accept this and to work together to meet the diverse needs of the residents of Cappahard Lodge.

We also understand that, following a recommendation from the Mental Health Commission, an application has been made to designate Cappahard Lodge an approved centre under the provisions of the Mental Health Act (2001). This will help to address some issues, notably around the need for detention, avoiding having to transfer residents out for acute episodes of mental health care. It would also clarify the issue of primary medical responsibility (see our sections on health care and deprivation of liberty for more on this).

We accept, however, the valid point made by the Consultant Psychiatrist that the policies required by Mental Health Act regulations may be less relevant for residents with dementia in Cappahard Lodge than the standards being drafted by the Health Information Quality Authority (HIQA) for care facilities for older persons. In our review of policies and procedures, we have been mindful of both sets of standards when assessing the adequacy of existing policies and making recommendations for improvements. There is no reason why HIQA standards could not be used to supplement the policies required by Mental Health Act regulations.

Section 4: General comments on good care and areas for improvement

4.1 Introduction

We asked everybody we interviewed what was good about the care given in Cappahard Lodge and what suggestions they had for improvements. We have analysed some of these issues in greater detail but the messages from these two straightforward questions are interesting and encouraging.

4.2 What was good?

Residents who were able to communicate with us were very complimentary of the staff and of the care they received.

Relatives told us:

- “Everything was good. We couldn’t find any fault in it. When he went in for respite, he was in there twice, and we saw how relaxed he was in there. They were friendly, they treated him like a friend over there and when he’d see the nurses coming into his room, his face would light up and we knew he was content. They had so much patience over there with him. I have nothing only good to say about Cappahard and the care he got in there.”
- “Everything. The one thing I will say is the first day X went in there it was made clear that it was a Lodge, not a home and they were residents, not patients. He has only ever been treated with the highest respect for a man who has Alzheimer’s. They are trying to keep his dignity, which is very hard to do for a man with Alzheimer’s, as much as possible. They are caring for him with the highest standards.”
- “She is getting very good care from the nurses there. Looking at all the patients myself, they all look very healthy and I think the nurses are doing an excellent job”
- “There were staff in there who came across as being, they came across as being able to empathise with the patients’ needs. There was one particular member of staff who was, for the first six months, very good to every patient in therehe was very, very, very good at what he did, but there were also some other members of staff, who I can honestly say

did have the best interests of the patients, but maybe their hands were tied as to how much they could do.”

- “Things are going on good there. The care is very good there. They invite us here and you would be offered a cup of coffee or something.”

The staff were asked the same question in an anonymous questionnaire. Examples of their responses were:

- “More people orientated, rather than task orientated. Very caring staff that have a genuine interest in the residents. Each is treated as an individual.”
- “With regard to their care, they can choose when they can get up, encourages independence for residents.”
- “Each client is treated with respect and dignity. A holistic approach to care.”
- “Time with each resident is quality time and to a high standard.”
- “Personal belongings, comfort and care in home like surroundings.”
- “Good nursing practice.”
- “Administered medication before meal time thus ensuring full quota of staff on duty.”
- “Resident’s needs are attended to 24hr basis, emphasis to make each day as enjoyable as possible for them.”

Lead medical staff and nursing managers told us:

- “Treating everybody with respect and dignity, I feel, is of much importance and I try through my professionalism to deliver that type of care to each individual that I encounter with during my place of work there. That would be my priority.”
- “I think the person centred approach is very good in Cappahard Lodge and I think it has added to the quality of life for the residents there.”
- “The person centred care project, and also the introduction and the use of evidence based practice into Cappahard Lodge, and I also think the new Primary Nurse system, the key worker system is working very affectively and is also enhancing the quality of care that residents receive.”
- “I think in general the standard of the nurses is very high and I think they, over time, develop a very good relationship with the patients and their relatives and provide many of the patients in Cappahard with a home that is their home where they are living rather than

just an institution, I'm not sure, about what staffing levels should be, but they seem pretty good as apposed to maybe private nursing homes."

- "I think what's good is the relationships between the nursing staff, and, indeed, actually the domestic staff, and the residents. Since we started our practice development project, we have moved into a different level of partnership with the older person, and, I think, because we have looked at values and beliefs, and thrashed out a lot of the ritualistic issues that, I suppose, govern the way that we interact with people....that we have actually done a huge amount of reflection, and the staff who have been involvedimproved their interaction with the person who is receiving the care."
- "In particularly over the last 1.5 years, I think it was about 1.5 years when the Assistant Director of Nursing, started instituting procedures to engender person-centred care. There has been quite a lot to be positive about regarding the care in the unit as in people are getting geared up and skilled up to deal with looking after people, particularly looking after people with complex dementia and I can see over the last while, despite all of the other hugely difficult and, you know, severely traumatic things going on in the unit over the last two years, despite that I can see that there have been some improvements in the general care that people are getting."

4.3 What needs to improve?

When we asked what was not so good and needed to improve, relatives told us:

- "They couldn't have done any better." (3 sets of relatives told us this)
- "She is smoking a little bit too much, all due to the medication that she is on. She is smoking an average of about 15 per day according to the nurse, so I said is it possible maybe over the next couple of months that she could try to start scaling down her smoking campaign altogether, otherwise I said she is going to wind up with severe chest trouble in the finish. The nurse said "we can't break her up from the smoking that she is on at the moment because she says she'll get fired up she said if she does". She's happy she says on the medication she is on at the moment, plus the cigarettes that she is smoking. Right. So there is no possibility of scaling her down on the cigarettes at the moment".
- "Well there were a lot of things I found wrong with the premises. As I said, first of all, it is a non-approved centre and has been non-approved for the 8 years that it has been opened. I had an issue with that from day one. During some of my own research, where

I printed off reports done by the Mental Health Commission, I had issues with the Report 2005 in particular, because they quoted it being the model of nursing used, was the Orem King and when I looked at the Orem King Model of Nursing, it was for people who were capable of taking care of themselves, dressing themselves, feeding themselves. My father and some other patients there were not capable of doing that, and it seemed to me that they didn't have a model of nursing to cater for people who couldn't dress themselves or feed themselves or take care of themselves. I had issues with the fact that my father was in a room on his own across from the smoking room. He had angina. The fact that there was no way for him to communicate from his room with staff and that was throughout the facility. I had particular issues at the fact that, although there were sink units in from the rooms, the fact was that they shaved them all from one basin, one razor, and one towel in the day room, and I found that very difficult."

The staff questionnaire revealed some concerns. These were varied, but staffing issues, activity for residents, privacy, and Consultant review seemed to be the most common themes. Examples of comments were:

- Some senior staff remains task orientated and institutionalized.
- Could have a more effective primary nurse system
- Inadequate staffing levels resulting in lack of activities with clients.
- More involvement with other disciplines in the team including Occupational therapy.
- Care assistants would help a lot especially as residents require complete care.
- Team work could be improved and more co-operation between all grades of workers
- No privacy, no blinds for windows and doors.
- Each resident should have an individual room and should not be sharing.
- Consultant should spend more time with residents and review them more frequently

Nurse Managers and medical staff told us:

- "I suppose giving our residents more choice. Giving them more of a say, treating them as individuals. That would be my priority and I think we are working and progressing towards that, and hoping to build on it."
- "I think getting everybody on board on the person centred care project is a thing that we have to work on as well and I also think, having appropriate staffing levels there, to give

that level of care, and I think we need better continuity of staff in order to get the primary nursing and the key worker working more effectively.”

- “The person centred care project and, I think, there is a lot of staff on board, especially a lot of the younger staff, but the staff that remained have re-orientated and, you know, are more slow to come on board. Having said that, they have come on board to a certain degree, but it’s just harder to get them on board. It takes more time. I think in regard to the respect and dignity of the residents, I have a huge thing about having no blinds on the windows. We have tried, as Nurse Managers, to get blinds for the windows because you could see directly into the lodge (from a nearby house), so that would be a big issue, and also, I think, it is more appropriate to have residents having rooms of their own, and yet at the moment we have two single rooms being taken up for storage space, and I have a big issue with that as well.”
- “I’d like to see greater involvement from the medical staff as well in Cappahard Lodge. Currently we have no set ward round.”
- “More education for staff and that staff would be given the days to attend these education sessions, because I think a lot of the slowness in taking on board the PPC project is lack of education on behalf of staff and, you know, when you talk to staff about it, they often say “well, its very hard to get the day back” or, you know, your know, if you do go to a course on your week-on, you could be working five days in that week, and that’s very hard for staff, so I think education would be a huge thing for staff, especially staff that would be in the unit, that would have a lot of years of experience, and although experience is a necessity, also they need to be up-dating themselves education wise as well, especially in relation to dementia care.”
- “I suppose possibly maybe a better enclosed kind of garden or outside area for the patients in the summer to spend time in or walk around in, possibly, well definitely more activities for the patients, more, possibly, occupational therapy, more physiotherapy, maybe more stimulation for the patients, but I suppose it’s dependent on resources that are available, but I definitely think that would be a big help if there was.”
- “I think we have only started on the journey of actually looking at good practice. I think it takes a long time to change the culture. It takes a long time to actually ...reflect on what we are doing. Try and empathise with the person who is receiving the care and then kind of move forward, but I think there are a number of barriers, particularly in Cappahard, to doing that; not least some of the traditional ritualistic practices that have kind of been handed down from the institution, and the rostering system and, indeed, I suppose leadership issues around where, you know, what the, going forward what, what

the vision is. I think we have, as a group of people who have been involved in the practice development actually have a very good sight of the vision, but it's difficult to actually get that message across to those who need to be supporting that vision into the future."

- "I think, what is not good is since the unit became a unit under the Health Service in March, 2002, there has never been agreement in the Health Service about what Cappahard was about and when it came into existence it was used to move a cohort of patients who inhabited two wards that were called psycho-geriatric wards in Our Lady's Hospital and those two wards had a group of people who had very mixed needs. It became clear to me that this was a very disparate group of people with very disparate care needs ranging from elderly people with complex dementia to younger, mainly women in their 40s and 50s with psychotic disorders, functional mental illness problems who were mixed in with this ward, as far as I could see it, only because there was no other place for them to go and these wards were locked so they were in effect being held in secure environment and then despite concerns that I raised about that in the months prior to the move and despite the fact that I did not even get the chance to finish my own assessments of the people I was trying to look after or provide my Specialist Clinical Care for – all of these people were moved en masse on one day into Cappahard Lodge on a day that I was given no notice of either, by the way, and on a day that I was on leave."

We also asked relatives whether they would recommend Cappahard Lodge as a good care facility to others in the same position. Their answers were:

- "I would and I have done. If I won the Lotto in the morning I'd give it to the nurses over there looking after him."
- "For any family tomorrow morning who would require it, for any member of their family, yes I would recommend Cappahard. Because the nursing care that is provided there to the patients is a very good quality of care."
- "I would of course because they are very good there. All the staff, every one of them, they are all nice, and the ward orderlies are nice."
- "I would. Highly. Highly and I wish to God every other one would take a leaf out of their book. Yes."

The one relative who had a negative view on this issue said that she would not have recommended it during the time the person she was visiting was in Cappahard Lodge. She qualified this by telling us that she was aware of improvements:

- “Residents get a cup and saucer and a choice of milk and sugar with their tea. They can get up and go to bed whenever they want. New furniture was ordered and major renovations were taking place, including extra toilets and most of the old staff has been replaced. So I don’t know what it is like now.”

4.4 Summary

Residents and relatives are mostly complimentary about the care in Cappahard Lodge. Staff attitudes came in for particular praise, most respondents commenting on the dignity and respect they gave to the residents. Smoking was raised by two relatives and one had concerns about lack of approved centre status and the model of care. This accords with the views of staff who feel, overall, that the person-centred approach is bearing fruit although some staff were thought to be slower to adopt this model. Clarity of purpose for the unit, privacy for residents, modernization of staff rostering systems, improved training and improved Consultant input were frequent themes. We will address all of these in our examination of policies and procedures in the unit.

Section Five: Review of Policies and Procedures

5.1 Introduction

The committee were provided with operating policies and procedures pertaining to the care of residents of Cappahard Lodge. We considered the requirements for policies under Mental Health Act regulations and under standards required by the Health Information Quality Authority (HIQA).

For each area where policy might be necessary, we wanted to know:

- Is there a policy?
- If not, is policy required?
- If yes, is the policy adequate and being adhered to? We assessed this by reading the policy, collecting evidence of its use from our visits to the unit, from staff questionnaires and from interviews.
- Recommended action based on our assessment.

5.2 General issue – Framework for policies

We discovered various policies in the form of notices, policies, procedures and guidelines. There appeared to be some confusion among staff as to the purpose, scope and meaning of the various documents. Their format varied considerably and there appeared to be no consistent structure to them. We recommend that the Area Executive develops a standard template for all written policies, procedures and guidelines. This template should be structured as follows.

Title – Standard Operating Procedure/Guideline.

Written / Reviewed by -

Approved by -

Purpose

This Template is to be used in the development of all Standard Operating Procedures (SOPs) and Guidelines.

Scope

All staff responsible for writing and managing policies, procedures and guidelines within their areas.

Definitions and Abbreviations

Responsibility

- Sets out the various responsibilities of:-
 - Heads of Departments.
 - Line Managers.
 - Individual staff members.

Procedure

Explain how the Template is used. A step by step instruction guide so that anyone picking up the document can clearly see how they are to perform the task in question.

Frequency of Review.

This indicates when the SOP is to be reviewed.

Review Methodology

Method used to review the operation of the SOP .i.e.

- Audit tools.
- Performance Indicators.

References

Any references that are relevant i.e. National guidelines. Normal reference etc.

Recommended action:

Quality Assurance, Continuous Quality Improvement.

It is the responsibility of the service to ensure that their policies and guidelines are quality assured prior to publication and distribution. From a continuous quality improvement perspective ongoing and active review of policies and guidelines should take place.

5.3 ADMISSIONS TO CAPPAHARD LODGE

Is there a policy?

Cappahard Lodge has an admissions policy.

Is it adequate and being observed?

Evidence from reading the policy:

Good points:

- It provides a basis for decisions on who to admit and not admit
- It should lead to an admission care pathway
- We found it clear and it should be easy to communicate to referring agencies, residents and carers

Concerns:

- Several statements containing “should”. Many of these appear to be “must” for safe care – e.g. availability of full summary of psychiatric history, medications etc.

- The policy suggest that a single unit purports to provide assessment and continuing care of people with dementia and also continuing care for older people with a functional illness as well as respite care. This appears to be a lot to ask of a single unit and could lead to problematic patient mixes
- There was no statement about prospective residents and carers being able to visit in advance
- For residents receiving continuing care, there was no statement about residents bringing their own possessions, individualizing room space etc. We also found no evidence of this in any other policy.

Evidence from our visits to Cappahard Lodge and inspection of case records:

We found:

- A mix of residents. During the period of the review, we found that around a third of residents had dementia. Most of the remainder were former residents of Our Lady's Hospital. We found that people most recently admitted had dementia, although there was a person with chronic depression admitted for respite care.
- An age range of people different from the age range stated in the policy. The policy refers to care of people age 65 and above. We noted that younger people with dementia were admitted to Cappahard Lodge.
- Discrepancies in the stated policy on assessment before admission. The policy states that staff from the unit will usually be involved in the pre-admission assessment. We found no evidence that this ever happened. The assessment appeared to be performed by the community mental health team. Although not formally stated in the policy, we found widespread documentation relating to the Camberwell Assessment of Need (CANE). It appeared to be expected that the CANE would be completed as a routine for people in the care of the community team. This was not universally done and we found records where there was a CANE proforma that had not been completed.
- We asked for written information on the unit that could be given to prospective residents and carers but there was no such document available.

Evidence from staff questionnaire:

Staff generally agreed that they were not involved in pre-admission assessment. Despite what was written in the policy, it clearly does not happen.

With regard to admission criteria, staff had mixed views on the issue of caring for people with dementia and people with functional mental illness in the same unit. Examples of responses were:

- Difficult given nature of dementia and continually short staffed
- Difficulties around mixed group of clients
- Difficult as each group has different needs
- With co-operation of relatives and staff not that difficult
- Very easy as the numbers are very small and treating everyone individually is the key to providing quality care.

Evidence from interviews:

- Relatives generally told us that they were given no information about the unit before the person was admitted. One person told us that she was given the most recent newsletter. Another relative praised the written information she received on dementia in general.
- We saw two relatives of people who had been transferred from Our Lady's Hospital. Both had been given little information about the proposed transfer. Given the planning that surrounded the closure and transfer process, we found this surprising.
- We interviewed relatives of a younger person with dementia. While the unit does not expressly cater for such people, they consider his placement there appropriate (and we saw no reason to disagree when we saw the resident in the unit). They did however speak of their difficulty getting access to assessment and diagnosis.
- The Consultant confirmed that staff from the unit were not routinely involved in assessment before admission. He also admitted that the CANE was not always used in the community, despite the expectation that it would be.
- The Assistant Director of Nursing and the Clinical Nurse Managers confirmed that there was no accessible written information about the unit and agreed that there should be.
- The Consultant had very firm views about the mix of residents. My impression is that it is not possible to provide for that mix in one unit if you want to provide best possible care. It is not appropriate to have someone with chronic schizophrenia in their 50s sharing the same unit and facilities as a lady with dementia in her 80s.

Recommended action:

In our opinion, the admission policy needs some amendments:

- In line with our recommendations about clarity over the purpose of Cappahard Lodge, the admission criteria need to be reviewed, taking account of the projected need within the catchment population, including the needs of younger people with dementia.
 - Prospective residents and carers should have written information on the unit. We recommend that the unit produces a written brochure/information leaflet
 - It would be best practice to include a statement to the effect that prospective residents and carers are welcome to visit Cappahard Lodge before admission.
-

5.4 IDENTIFICATION OF RESIDENTS

Is there a policy?

Cappahard Lodge has no policy.

Is a policy required?

Yes. In the interest of safety and from a risk prevention and management perspective a policy for the above should be developed.

The purpose of such a policy should be to ensure that residents are afforded health care in particular the administration of nursing and medical treatments in a manner that ensures their safety. Photographic identification would also help in searching for a resident who is missing from the unit

Recommended action:

Residents at Cappahard Lodge should be identifiable to staff through, as a minimum, the use of photographs placed on their medical file. Any additional means of identification should be achieved in partnership with the resident/relative and done in the best interests of the resident.

5.5 PRIVACY & DIGNITY

Is there a policy?

Cappahard Lodge has no written policy on privacy and dignity

Is a policy required?

Yes, both the Mental Health Act regulations and the HIQA standards require a policy in this area. In addition, the review process supports that a firm policy is required.

Evidence from our visits to Cappahard Lodge and inspection of case records:

Good points:

- The overall impression of the review is that the service strives to ensure that each resident's right to privacy and dignity is respected.
- Care Plans are personalised to respond to individual needs and preference
- The service is striving towards a nurse-led system of care plan reviews and a "Person Centred Care Approach"
- Staff demonstrates their respect for the dignity and privacy of the patient through
 - Their general demeanour
 - The manner in which they deal with, communicate with, and address the residents.
 - Through their appearance and dress
 - Through their obvious concerns and interest for each resident

Arrangements are in place to ensure that the residents' privacy and dignity is respected particularly in relation to:

- Maintaining social contacts
- Spending time alone as the resident wishes
- Wearing personal clothing
- Dressing and undressing
- Being assisted to eat and drink
- Personal care giving

- Entering bedrooms, toilets and bathrooms
- Access to telephone
- Receiving personal mail unopened.

Concerns:

Where residents share a room, full fixed screening is not always provided and residents' privacy can be compromised when personal care is being given. Staff did inform us that a portable screen is used in such circumstances but it is the view of the group that this arrangement is not satisfactory.

The front windows and doors in Cappahard Lodge are not screened and consequently residents can be seen from the adjacent houses – a particular problem at night for people who are up and about in their night attire. There are curtains in bedrooms but these are cumbersome for some frail older people to use. Residents' privacy is seriously compromised as they can be seen when dressing and undressing in their bedrooms. Screens or blinds would be better.

Toilet doors were found to open directly onto corridors and could not be locked from the inside. (Renovations are currently underway to address this issue). One person receiving respite care was unhappy about the lack of privacy in toilets while generally complimenting the care she received.

There is no canopy at the front door to Cappahard Lodge so people visiting may be forced to wait in the rain etc while staffs are summoned to open the door.

Some rooms lacked individual possessions and this did not contribute to an atmosphere or sense of individualism.

There was evidence of bulk supplies of soaps, shampoos etc in bathrooms which instilled an institutional atmosphere.

A commode was found beside a bed in a twin room. The committee were concerned about the privacy and dignity of residents using same however staff reassured the group that they are always screened when using the commode.

Evidence from staff questionnaire:

These are quotes from members of staff:

Good points:

- Cappahard Lodge is more client-oriented than task-oriented. Staff are very caring and have a genuine interest in the residents. Each resident is treated as an individual.
- They have a choice as to when they get up, this encourages independence.
- Each client is treated with respect and dignity.
- Residents have personal belongings and comfort and care in home like surroundings.
- Cappahard Lodge provides a holistic dignified, quiet, comfortable, caring and positive environment.

Concerns:

- Some senior staff remains task oriented and institutionalised.
- Some senior staff feels that residents do not have an opinion.
- No privacy, no blinds for windows and doors.
- Each resident should have an individual room and should not have to share.

Evidence from interviews

Good points:

Relatives interviewed were generally happy with privacy and dignity issues.

- One reported that the family member was treated with dignity and privacy and in fact privacy had improved since Cappahard Lodge had opened.
- Another relative stated that his father had “only been treated with the highest respect for a man who had Alzheimer’s. They are trying to keep his dignity, which is very hard to do for a man with Alzheimer’s as much as possible. They are caring for him with the highest standards”. The same relative also complimented the staff on how patients were toileted in a private and dignified manner during a Christmas party.
- Another relative complimented the staff of Cappahard Lodge
 - “the kindness of them”

- “they treated him (resident) like a friend”
- “the (resident) would see the nurses coming into the room, his face would light up and we knew he was content”
- “I have nothing only good to say about Cappahard Lodge and the care he got in there”
- “they couldn’t have done any better for him
- Another relative stated that Privacy and Dignity issues were better in Cappahard Lodge than in Our Lady’s Hospital.

Only one relative expressed concerns about privacy and dignity. She told us that:

- Male residents were shaved using a wash hand basin in the day room and that the same razor and towel was used for everyone.
- Residents used the commode on the corridor in front of visitors albeit with a screen provided for privacy.
- There was a toilet across from the day room and the door would often be left open.
- While in her father’s room she observed in the bathroom across the corridor on one occasion a man was having a bath while at the same time another man was at the sink.
- On one occasion while residents were watching T.V a nurse picked up the remote control and switched the channel to a programme she wanted to watch without asking the residents.
- On one occasion a resident was a few minutes late for her tea and when she asked for a cup of tea she was told by a member of staff, “it’s over, you are not getting any”.
- It was the “job” of one of the residents to clean the toilet. “He would go in and clean the toilet and stick the mop back into the same water and then take it out again”. The same patient was sweeping and washing out the smoking room at 11.15 p.m. one night and a visiting G.P noticed him and expressed his concern to the resident.

We were impressed with the attitudes of staff to privacy and dignity of residents. Priorities for staff in relation to privacy and dignity were:

- The pursuit of the person centred approach to care as it added to the quality of life for the residents
- The introduction of evidence based practice.

- The primary nurse and the key worker systems.
- Giving residents more of a say and treating them as individuals.
- Giving the residents more choice particularly in relation to meals, the only meal choice is at breakfast. Staff not permitted to prepare snacks for residents outside of main meal times.
- The lack of blinds on the windows and screens on the doors.
- The lack of bed curtains and partitions in rooms where there are more than one resident.
- The lack of privacy in toilets with doors opening directly onto corridors. These issues are being addressed currently – after much representation and lobbying from staff.
- The lack of a “call-system” in the toilets for residents to enable them summon help.
- The need for the current space which is occupied by the laundry to be reclaimed by the Unit. This would enable Cappahard Lodge to have mostly single occupancy rooms and enhance the privacy and dignity of residents.

Recommended action:

Cappahard Lodge must have a policy on privacy and dignity. This needs to address

Structural issues:

- The provision of fixed screening / partitioning in shared rooms.
- A move to single occupancy rooms where possible. The current laundry storage should be relocated and the space converted to increase single room provision.
- The provision of a canopy type structure at the front entrance to Cappahard Lodge.
- The provision of blinds / screens on all external windows and doors.
- The completion of renovations to toilets to provide privacy to residents. This will be achieved through the provision of a lobby onto which toilet doors open. Toilet doors should also be fitted with a locking mechanism which can be over-ridden by staff and all toilet doors should open outwards. The provision of a call system in toilets.

Individualisation:

- The provision of personal items such as pictures, photos and mementos in individual rooms.
- A move away from the use of bulk products i.e. shampoos, soaps etc.

Choice

- The increased involvement of residents (and where appropriate their relatives) in their individual care planning. (The person centred care approach which is being introduced will help achieve this objective).
 - The provision of greater choice to residents in relation to meals. This can be achieved through the introduction of a menu card system where residents can choose from a set menu each day. The issue of staff being prohibited from preparing snacks for residents should be re-examined in order to promote the concept of choice and normalisation.
-

5.6 RESIDENTS' PERSONAL PROPERTY

Is there a policy?

Yes.

Is it adequate and being observed?

Yes.

Comment

During the committees visits to Cappahard Lodge it was noticed that some of the residents' bedrooms lacked individual or personal items. This had the effect of creating a clinical and somewhat sterile atmosphere/environment. In contrast, residents' rooms that contained personal items appeared very homely and normalised.

The encouragement/promotion of the individualisation of private rooms would enhance their appearance and have a normalising and positive effect on the environment and the residents.

5.7 MANAGEMENT OF RESIDENTS' FUNDS

Is there a policy?

The Patients Private Property (PPP) Account is a system which applies in all public service long stay nursing homes. The scheme is governed by extensive Interim Guidelines issued in March 2006.

In December 2006 a Patients Private Property Account Central Unit was established by the HSE in Tullamore, initially to receive all payments from the Health Repayment Scheme being paid to HSE client's PPP accounts. Phase 2 of the project is to transfer excess funds in individual accounts from the local care centres to the Central Unit with the agreement of the individual residents in all cases where capacity is not an issue. All funds held in the Central Unit are invested with the National Treasury Agency and interest earned is assigned back to individual accounts on a weekly basis

Is it adequate and being observed?

The local arrangements work well in Cappahard Lodge. The Committee was told that individual residents' funds are utilised on an ongoing basis for the provision of personal items for the sole use of the resident involved. Expenditure in excess of 400 euros requires approval from the Assistant Director of Nursing. All those interviewed, including relatives, felt that the system worked very well and there were no complaints.

On a general policy aspect two relatives felt that advice and information on financial affairs should be given to residents and their families at the earliest possible date to allow them to make appropriate financial and legal arrangements for the future.

Recommended action:

The Interim Guidelines on PPP accounts be updated and finalised as soon as possible and the HSE should examine arrangements whereby patients and relatives could be advised to seek legal and financial assistance at the earliest possible stage of diagnosis of a progressive debilitating illness such as dementia.

5.8 ASSESSMENT AND CARE PLANNING

Is there a policy?

We found no overall policy on assessment and care planning. We reviewed the standard care plan documentation in the unit. Cappahard Lodge has been moving towards a person-centred care approach and we reviewed material relating to this. While not yet firmed up as policy, we found many encouraging statements that indicate a positive and respectful attitude toward residents.

Is policy in this area needed?

Yes. Both the requirements of mental health act regulations and the HIQA standards require policy in this area. In addition, our assessment of the process of assessment and care planning suggests that firmer policy is needed

Evidence from our visits to Cappahard Lodge and inspection of case records:

We examined care plans of present and former residents. We chose four to assess in detail. This is what we found.

- There was often a lack of clarity over who was the named nurse or key worker
- We saw an approach to assessment that is based on perceived problems or deficits. Needs assessment seemed to be an aspiration (see the section on admissions policy) but is performed in the community. We found no evidence of the use of a comprehensive needs assessment tool in the unit
- Care plans were present in all cases, with good processes for nursing updates
- There was variable practice in reviewing care plans. The service is striving towards a nurse-led system of care plan reviews, with a major review every nine months. We found care plans that had not been reviewed within that time frame. We found that nursing staff were involved in the review. Medical staff usually had an input but found little evidence of other practitioners or relatives being involved.
- An audit of care plans showed that 35% of residents were overdue a review. We thought that the Clinical Nurse Managers were very thorough in auditing this area of practice and would encourage them to implement the lessons learned.

- We think it is important that older people, especially people with dementia, have a record of their life story. Some assessments contain basic details of family, marriage, occupation etc. but we found no evidence of comprehensive life stories.
- We also think it is important to record people's likes and dislikes. We found that this was done well.
- It is also important to get an account of the resident from someone who has known the person well for some time. Assessment and care plan documentation for people with dementia should have a major section devoted to this. We found some brief information from carers but thought it needed to be more structured to get a clear picture of the individual.
- We had concerns about specific aspects of care plans, notably falls, diet and nutrition. These are addressed in our section on health care. In addition, we have dealt with provision of therapeutic and recreational activity in a separate section, given that specific policy in this area seems to be necessary.

Evidence from interviews with relatives

We were particularly interested in wider participation in assessment and care planning beyond the medical and nursing staff in Cappahard. We asked several questions of relatives and staff. Relatives almost unanimously spoke of being made to feel welcome at all times. However, we heard mixed views from relatives about involvement. Examples were:

- "If he had a cold, they ring me up straight away. He gets blackouts as well and straight away we are phoned. We are never left in the dark."
- "You could have your say. The Consultant would call me in and ask if I had any complaints or "do you think we could be doing anything better for him than we're doing"
- "They are always giving you information – you don't have to be asking them. They just tell you. "Today he got up at this time, he was aggressive"".
- "I don't get involved. I don't ask because she's getting the best of care."
- "They should maybe spend a little more time with myself. They are under more pressure with the patients, so they won't have time to sit down with any member of the family."

One relative spoke of difficulty getting information because of not being the next-of-kin.

- "If I asked a question it was always referred to as if it had nothing to do with us, it was to do with the next-of-kin, and, therefore, they couldn't discuss it with us. We felt very excluded, not having anything to do with our father."

We also wanted to know if relatives felt that the key worker or named nurse systems worked. We found that relatives might develop a relationship with a particular nurse but none were aware of any named nurse system

- “There used to be a nurse who took most to do with her but she retired. I don’t know who it is now.”
- “There is one nurse I like – she goes out of her way to do things for X. But I haven’t been told she’s the one I go to if I have any queries. They are very nice nurses all over.”
- “There was one nurse, he loved her. But there wasn’t a special nurse.”

We also wanted to find out what information relatives were given more generally about the condition for which the resident was being treated. Knowledge tended to vary, depending on the level of understanding the relative had and his/her access to other sources of information.

- “X (nurse) would come and explain everything. He explained to us what happened with Alzheimer’s and the brain.”
- “She has an illness. The staff only say that she is fine. They have no problems with her.”
- “Schizophrenia – my father told me there would have been a split personality. I haven’t had a word with a nurse or doctor since she went in.”
- “We thought it was Alzheimer’s and got information off the internet.”

Evidence from interviews with staff:

We discussed these issues with the staff in the unit and they agreed that there were some things they could improve.

- The Clinical Nurse Managers saw the introduction of life stories as being integral to person-centred care. They are looking to implement life story work in the near future
- They admitted that they did not routinely invite relatives to reviews
- They told that they had done a lot of work on reviews of care plans. In response to the audit, they are working on recommendation to improve the scheduling of reviews. This seems to depend on the primary nurse system working well
- All staff were highly committed to the principle of person-centred care. The nursing staff we spoke to in the unit understood the concepts and thought it had made a difference to their practice. Nurse Managers and the Consultant agreed although we heard that some staff had taken longer to embrace the concepts.

Recommended action:

We commend the work to implement person-centred care. We recommend that this work is translated into policy.

- There should be a fundamental review of care plan documentation and process, underpinned by a policy statement and by the values of person-centred care. Needs assessment and life stories are important parts of care planning.
 - Care plans should be multidisciplinary. They should be informed by assessments from all professionals involved in the person's care. Care plan reviews should involve all disciplines, the resident where possible and the nearest relative(s). The primary nurse/key worker must have the responsibility for organizing care plan reviews, and keeping relatives informed and involved.
-

5.9 GENERAL HEALTH CARE

Is there a policy?

There is no general policy on health care in Cappahard Lodge. Some specific policies are present – for example care of the dying and medication prescribing. Other important specific health care issues have no policy statement but there are processes in Cappahard Lodge to manage them – e.g. falls.

Is policy needed?

Yes. We identified several issues that suggest to us that an overarching policy on health care is needed. Such a policy would be required were the unit to be an approved centre and would also be needed to comply with HIQA standards.

We identified a fundamental problem regarding medical responsibility. While the Consultant Psychiatrist has admitting rights and responsibilities, the residents of the unit are on the general practitioner's general medical list. In practice, the Consultant takes responsibility for mental

health care and the general practitioner provides physical health care. When we interviewed the medical practitioners, there was disagreement on primary medical responsibility:

- The clinical director believed that the consultant psychiatrist was primarily responsible
- The consultant thought the GP was primarily responsible
- The GP agreed that he probably had primary responsibility but deferred to the consultant for mental health issues.

In reality, we think there is a shared care model but the responsibilities of the consultant and GP are unclear and the liaison between them is uncertain. They told us that they communicate by phone where necessary but seldom meet to discuss overall health care issues.

Evidence from our visits to Cappahard Lodge and inspection of case records:

We found no evidence of regular routine physical examination. In our opinion, there should be at least an annual review of health care, taking account of physical and mental health needs. As an example, we found a resident with dementia who had a physical examination on admission 2 years previously. Other than one examination of her chest when she had a bad cough, we found no other physical examination since admission.

There was evidence that blood tests to identify and monitor physical health problems were performed appropriately, although we identified one resident who showed a high blood glucose level that was not followed up. We did not find evidence of routine urine examination – simple, cheap and effective in identifying significant health problems at an early stage.

Several residents were prescribed medication for mental health problems, including antipsychotic drugs and sedating antidepressant drugs for people with dementia. We found no evidence that any person was inappropriately sedated. We also saw good evidence that the Consultant regularly reviewed medication. He made attempts to reduce medication where possible. For example, we reviewed the records of a person with dementia and challenging behaviour and found frequent adjustments to medication with a reduction over the previous 2 months as improved nursing management was reducing the need for medication.

We had some concerns about monitoring of adverse effects of medication. While we saw no person being excessively sedated, we saw little documentation of movement disorders – a

frequent and troublesome adverse effect of antipsychotic drugs. There was a system for checking blood levels of medication where appropriate.

We had concerns about checks on nutritional status. Most people had been weighed regularly (although see section on recording clinical information). When we visited, the sit-on scales were broken so it had not been possible to weigh anyone who could not stand. We hope this will have been rectified by the time this report is published. Of greater concern was that no measurement of body mass index (BMI) was apparent in any of the residents.

Also on the subject of nutrition, there was no evidence of dietician input to the care of residents we saw. This was in spite of a significant number of residents with dietary needs because of diabetes or difficulty swallowing. Dietetic involvement would also emphasise the importance of BMI in assessing and monitoring nutritional status.

We also found that there was no availability of speech and language therapy (SLT) involvement. SLT assessment of swallowing reflex is an important safeguard against choking in people with dementia.

Outside office hours, there is an emergency general practitioner service. We found no major problems with health care although the emergency GPs often did not write in care records.

We found several people who were transferred to general hospital because of physical illness.

Many residents appeared to smoke. While there was a smoking room, some people lacked the judgement needed to stay in the room to smoke. Also, there was a smell of smoke in the corridor outside the smoking room.

Evidence from interviews

The issue of smoking was raised by relatives:

- “I wanted to know if it would be possible for her to cut down smoking. The nurse said “we can’t break her up from the smoking she is doing at the moment because she’ll get all fired up.”

- “My father’s room was across from the smoking room. He had angina. Smoke was drifting across all the time.”
- “Patients in there will always smoke heavily. The door is always shut. There was a garden with seating but nobody encouraged them to go outside to smoke.”

We raised smoking issues with staff.

- Clinical nurse managers told us that they did their best to keep the unit smoke free. They did their best to restrict smoking but it was not easy
- We asked the GP about healthy living advice but he was clear that his input was largely reactive and that he did not have the resource to provide proactive healthy living advice. He also told us that he saw a lot of people smoking and that the nurses would often “give them a cigarette to keep them quiet”.

Relatives were generally content with physical health care issues. However, one relative questioned nutrition in the unit and especially the soft diet provided.

- “He was getting potato and soup mixed together. It didn’t seem nutritious and didn’t smell very nice.”

Another relative told us that there was a proposal to transfer the resident to a general hospital because he needed intravenous fluids. This particular relative wanted the resident to stay in Cappahard and the nurses arranged to treat him with IV fluids in the unit. This seemed to be unusual within this unit.

Most relatives appeared happy with medication prescribed for mental illness and appreciated the need for it. We heard one allegation of overuse of medication. Other concerns around restraint, falls and palliative care are covered in special sections of this report.

From interviewing staff, we found the following:

- The GP also told us that he was performing regular annual physical examinations for residents when he started to provide input to the unit. He had been told that it was policy but the practice did not continue. He did not think he was being remunerated for this aspect of service.

- The Consultant told us that he had tried to devote a specified time per week to the unit but admitted that he had not been doing that of late. Workload issues made this difficult. “I have at several times tried to set up timetables of doing regular clinical reviews, on what we had last timetabled was an afternoon every two weeks but I also supervise a non-Consultant Doctor who has a regular session on an afternoon every week there and I would be dealing with queries and problems several times every week so it is hard to quantify. It is currently not satisfactory because it is currently not possible to properly conduct my business in the Unit because of everything else that has been going on, not only the difficulties over the last two years relating to one specific case which has probably taken up around 2,700 hours of my time personally, not only because of that because of the uncertainty what the unit is about”. The Consultant subsequently confirmed to us that around half of the 2,700 hours was outside his contracted work time.
- Both the Consultant and GP admitted that they did not liaise over clinical issues on a regular basis. They would discuss problems on the telephone but there were no regular joint meetings. They recognise the need for such meetings and have undertaken to address this.
- The Clinical Nurse Managers agreed that the choice of food was limited and the soft diets unappetizing in appearance. They admitted that soup with mashed potato in it was not unusual.
- Nurse Managers had differing views on managing residents on IV fluids. Some felt more confident than others in doing this.
- Nursing staff were aware of common side effects of psychotropic medication but there was no systematic recording of presence or absence of adverse effects. The Consultant was very wary of antipsychotic medication and tended to use newer treatments for dementia in the first instance.
- Staff confirmed that there was no input from a dietician. The Consultant told us that there was a dietician at Mid Western Regional Hospital, Limerick but Cappahard residents have no access to the service.
- They also confirmed that there is no speech and language therapy available. The manager of the SLT service stated that, due to insufficient resource the service was currently available only to people with neurological impairment such as stroke or Parkinson’s disease. Alzheimer’s disease and other forms of dementia are also neurological disorders with similar consequences. We consider it discriminatory to deny them access to such a service.

We understand the constraints on resources and the pressures on the Consultant. However, for the benefit of the residents of Cappahard Lodge, we believe that improvements are necessary and that practical difficulties are discussed and resolved.

Recommended action:

- As a matter of urgency, the issue of primary medical responsibility needs to be clarified. If, as it appears in practice, there is a shared care model, this should be clarified in a written protocol. Depending on the future status of the unit, it might be worth examining a different model of physical health care input from the GP rather than the GMS arrangement that exists at present. Our view is that it would be preferable for the Consultant to have primary medical responsibility as this would help to resolve other difficulties surrounding regular examinations and reviews.
- The unit needs a policy on physical health care. This should include regular (no less often than annual) physical examination, health promotion work and action to help people reduce smoking and facilities to ensure that no non-smokers are exposed to passive smoking.
- The Consultant must have a regular fixed commitment to the unit. The difficulty in doing so because of workload must be resolved between the Consultant and the Area Executive. Ideally, the GP should be present for at least some of these meetings to facilitate good communication. The need for such a commitment is independent of the uncertainty as to the purpose of the unit but is dependent on resolving the issue of primary medical responsibility. (We understand that, since we undertook our visits and interviews, the Consultant has a fixed commitment to Cappahard Lodge and we welcome this development).
- Dietetic and speech and language therapy input should be available. These inputs would lower the risk of poor nutrition and choking.

5.10 MANAGEMENT OF CHALLENGING BEHAVIOUR

Is there a policy?

There is no overall policy on management of challenging behaviour. There is a policy on the use of restraint. Also, despite the absence of policy, we found some very good practice in assessing and managing challenging behaviour.

Restraint policy:

Is it adequate and being observed?

Evidence from reading the policy:

We thought that the restraint policy was good and comprehensive. It had a wide definition of restraint and appeared to deal with all uses of restraint appropriately.

We thought there were two improvements that could be made.

- The policy defines some forms of restraint as (for example) “inappropriate use of bed rails”. We thought the word “inappropriate” should be removed. Restraint is restraint, whether the person performing it thinks it is appropriate or not.
- We thought that the use of restraint should always be based on an individual assessment of risk and always prescribed by a registered medical practitioner. The policy should reflect this, although we saw examples where this was done very well in practice.

Evidence from our visits to Cappahard Lodge and inspection of case records:

We saw no evidence of the use of direct restraint. We saw no residents in chairs from which they could not get up. There was some use of bed rails.

Medication can be used as restraint. However, we found no evidence that any resident was sedated to the extent that they were unable to rise or walk freely and safely about the unit. In reviewing care plans, we saw no statements about the use of physical restraint.

We saw care plans that gave a detailed analysis of a person whose behaviour was difficult to manage. The care plan included a detailed analysis of the causes of difficult behaviour. It also included a range of interventions, including one-to-one contact and reassurance, removing the person from the situation in which there was a problem and the use of the sensory stimulation room. Medication was only to be given if the above steps failed. We checked the nursing notes and saw that the plan was being followed, resulting in fewer occasions where “as required” medication was used.

Evidence from staff questionnaire:

Most staff told us that restraint was not used. A few staff mentioned bed rails: it is possible that other members of staff did not see this as a form of restraint. They responded that they would report the use of inappropriate physical restraint to clinical nurse managers if this happened.

Evidence from interviews with relatives:

Relatives of one person who had been mechanically restrained in the past had mixed views. There had been consultation with relatives over its use (as per the policy) and some relatives thought it was necessary and did not cause distress:

- “I got a form telling me about the restraints and signed it to say that it was OK.”
- (Without the restraint) “When the nurse turned, he got out of the chair and fell to the floor.”
- “He got used to it after awhile. He kind of go to move and then he’d feel it and he wouldn’t try to get out.”

The other relative disagreed.

- “He was shaking, and he was uncomfortable and I asked the nurse to remove the restraints from him.”

A relative of another resident told us of episodes where direct physical restraint may have been required.

- “Some male patients will flare up and I saw on a few instances there, they did flare up and very badly. The nurses as such just weren’t able to control them and they eventually had to get a couple of male nurses to control them and to hold them down.”

However, when pressed further on this, it seemed that the presence of male staff resolved the situation without the use of physical force

- “They didn’t use any force or anything, they couldn’t once they had the back up then of the male nurses like, you know. Now the male nurses didn’t use any force on them. I saw that for myself.”

Evidence from interviews with Staff:

All the staff interviewed was opposed in principle to the use of restraint. For example, the clinical nurse managers told us:

- “I would see restraint as a very, very, very last resort. I would be looking at every other possible option.”
- “It takes from their independence. We must look at all other diversional therapies rather than restraining an individual. We are aware of the research that shows it is actually more detrimental to a person, to have them restrained.”

We did not find evidence of significant mechanical or chemical restraint nor did we have any concerns about the attitude of staff. Our impression is that staff have moved away from using restraint and we would encourage this. With small amendments, the policy should stay in place for the rare occasions where restraint may be necessary. We did not see any use of direct physical restraint but took note of an account from a relative of this practice.

Recommended action:

- The unit has shown us evidence of very good practice in behaviour management. We recommend that this is incorporated into a broader policy on managing behaviour that staff find to be a challenge.
 - Restraint inevitably results in deprivation of liberty. There may be times when unplanned restraint in an urgent situation is necessary because of duty of care. Where this is foreseeable and interventions to provide restraint are planned, there appears to be no protective legal framework. This is discussed further in our section on legal issues.
-

5.11 FALLS

Is there a Policy?

There is no “policy” on falls management

Is a policy required?

Yes - a standardized falls risk assessment and management plan (the FRASE) is in use. We commend the use of this type of assessment and found that it was well used in the people whose care plans we studied. Just under half of the staff had been trained in the use of the FRASE – sufficient to ensure that all residents can be assessed by a trained member of staff but it would do no harm to train all qualified nursing staff. The FRASE requires that all residents rated as at high risk of falling should have an assessment by a physiotherapist. From our visits to the unit and examination of records, we found residents rated as being in the high risk category but where there was no physiotherapy input.

Evidence from interviews with relatives:

One relative told us that he/she offered to pay for physiotherapy input for a resident but this request was rejected. She also expressed concerns about falls.

- “One particular patient had 20 stitches, sutures, at the top of his head. Three patients were taken to the General Hospital that week end for stitching and my relative was taken for X-ray.”

Evidence from interviews with Staff:

Staff admitted that there was a lack of physiotherapy input.

- “Our residents have to be referred through the G.P. and, need I say, have to be on a waiting list, and then the appointment comes through, and we follow through with the appointment. We could be waiting anything up to maybe six weeks for follow-on for physiotherapy.” (Clinical Nurse Manager)
- “I have never seen a physiotherapist in the Unit, not in my time.” (Clinical Nurse Manager)

The Clinical Nurse Managers also told us that they had raised the issue of falls and physiotherapy input with the Risk Manager. It is not clear what action arose from this.

The Consultant also raised this as an issue:

- “I have tried and tried and failed to get physiotherapy services in Cappahard Lodge itself. I met with the response all the time that the people in Cappahard Lodge can queue up with out-patients from the general community over in the out-patient physiotherapy department in the elderly care facility, St. Josephs Hospital.”

The GP shared these concerns

- “There’s no physiotherapy available in Cappahard Lodge, the only facility open to us is to refer them to is the Geriatrician in St. Joseph’s Hospital, which is a geriatric hospital. We can refer them there; they would usually wait about 6 to 8 weeks for an appointment. It may not be what they need.”

Recommended action:

In our opinion, residents in Cappahard Lodge have a specific need for physiotherapy input. The HSE should determine the need for such input as part of a strategy to reduce the risk of residents falling and sustaining serious injury.

5.12 ABSCONDING

Is there a policy?

There is a policy on absconding with guidance on action to take.

Is it adequate and being observed?

Evidence from reading the policy:

- The policy is clear, easy to follow and gives good guidance to staff on how to respond if a resident goes missing.
- We support the policy. Minor improvements are possible: we suggest that a search time of 30 minutes could be stipulated as a maximum and that relatives, if contacted at an early stage, could provide ideas as to where the resident might have gone.
- Photographic identification would be of benefit as per our recommendation on identification of residents

We were satisfied that this policy provides appropriate safeguards for people who abscond. It was not possible to assess how the policy is implemented on site. Episodes of absconding were few although staff identified it as a risk. However, the unit is secure and the risk of absconding is low. Our comments in this area relate more to deprivation of liberty. See page 97 for our views on this.

5.13 RESPONSE TO MEDICAL EMERGENCIES

Is there a policy?

There is a policy on medical emergencies that covers Cappahard Lodge

Is it adequate and being observed?

The policy covers the basics of how to respond to an unconscious person. It mentions techniques for basic life support and refers to mandatory training in this area. We had some concerns about the policy. It contains no statement about regular training; this is included in the mandatory training document but it is so important that repeating it in this policy would not go amiss. Also, there is nothing in the policy about life support beyond basic. While perhaps not directly relevant to Cappahard Lodge, there are some facilities where we would expect defibrillators to be available and where some staff are trained in their use. Also, the policy does not specify availability of medication to combat common medical emergencies in mental health care. Acute anaphylaxis and dystonia following administration of antipsychotic medication would be the most likely acute situations and units such as Cappahard Lodge must be able to offer quick relief.

Recommended action:

The policy on medical emergencies needs some revision to specify training requirements, responses to common emergencies and, where appropriate, advanced life support.

5.14 PRESCRIBING AND ADMINISTRATION OF MEDICATION

Is there a policy?

There are policies covering these areas. We identified:

- Prescribing, administration and use of drugs
- Dispensing of medication
- Nurses and midwives guide on medication
- Errors in administration of medication

Are they adequate and being observed?

Evidence from reading the policy:

Prescribing policy: we found this clear and easy to follow. Following the policy would go a long way to ensure good medical treatment and protection from harm. We had a few observations that might improve the policy.

- We thought that the policy should expect a daily maximum dose for “as required” treatment.
- For controlled drugs, there must be safe procedures for recording use and preventing misuse by staff, including medical practitioners. Where a medical practitioner signs a requisition, someone else must collect the medication. This was a key recommendation from the Shipman investigation.
- For prescription records, the policy should specify warning stickers for residents with the same or similar names

- We concurred with the policy on the use of generic names. Where a proprietary brand is specified, nursing staff should obtain advice from a medical practitioner or pharmacist before administering any other brand of the same medication.
- The policy allows residents to keep their own medication in their possession. This does not happen in practice and it may not be safe. Self medication, as part of rehabilitation, may need separate guidance.
- The policy makes no mention of issues of consent or of administering medication covertly to residents with dementia who may lack the understanding necessary to make informed decisions to take or refuse medication.
- We note that only medical practitioners can prescribe. We know of arrangements elsewhere for other practitioners, especially nursing staff, to prescribe from a limited list of common treatments that people would administer to themselves at home.

We had no major comments on the other policies, although some statements in the policy on medication errors contain the word “should” where “must“ is more appropriate to deal with serious issues of administration of medication in error. We noted significant overlap among these policies.

Evidence from our visits to Cappahard Lodge and inspection of case records:

Largely, the policies were observed well. Medication errors were few (three in one year, all investigated appropriately). The only major issue was the use of proprietary brands. We found a significant use of non-generic prescribing. Most of this prescribing seemed to be initiated by the GP. For example, the GP often prescribed “Istin” instead of generic amlodipine. The latter is a fraction of the cost of Istin.

Minor remedies such as paracetamol for pain were prescribed by medical practitioners. This seems to be an unnecessary drain on medical time and easily within the expertise of a competent nurse.

Evidence from interviews:

Generic prescribing: the GP did most of the prescribing, especially for physical ailments, yet seemed unaware of the prescribing policy.

- “In general generic prescribing is good practice and proprietary prescribing should only be if there was a particular type of formulation that it is important that this person have.” (Consultant)
- “I worked in Edinburgh myself and I know that there is a lot more generic prescribing going on in the U.K. than there is in Ireland, and I think it’s probably a good idea. I’m used to prescribing brands a lot of the time. I’d say the Consultant would be mostly generic prescribing but it might be me that’s prescribing the brand named products.” (GP)

There was broad support from senior staff for the introduction of procedures for nursing staff to administer medication for minor ailments. Staff nurses in the unit, in response to the questionnaire, were less confident and thought that only senior staff with special training should be able to do this.

We asked about the use of covert medication. There is no policy on this but some staff told us, via the questionnaire, that they sometimes gave medication covertly. We think it is important to have policy and guidance for staff on the use of covert medication to ensure it is used safely and appropriately.

Recommended action:

- The policies on medication prescribing, administration and recording of errors are generally good. The Area Executive should consider some minor amendments and consider combining them into one document. This should include guidance on covert medication. Limited list prescribing for minor ailments should be within the competence of appropriately qualified nursing staff. We would encourage progress towards this
- Much prescribing is done by the GP. He is not an employee of the unit but we consider that he should follow the prescribing policy. Prescribing audits, especially of generic versus proprietary prescribing, would be worthwhile.

5.15 FOOD AND NUTRITION

Is there a policy?

No

Is policy needed?

We think this is a serious omission. Such a policy is required by both the Mental Health Act and HIQA standards and would be expected of a care facility for older people. Some points about nutrition are covered elsewhere in this report but they bear repeating.

- Residents are not offered a choice of meals
- There is no dietician with a regular input to Cappahard
- Staff and relatives agree that soft diets are poorly presented and unappetizing
- The system for weight recording needs to be improved and all residents must have a measurement of body mass index
- The unit must have scales available for weighing people who cannot stand. These scales must be functional at all times.

Recommended action:

Managers must develop a policy on food and nutrition. This policy must cover the points raised in this report

5.16 RECREATIONAL AND THERAPEUTIC ACTIVITY

Is there a policy?

No

Is policy needed?

We think this is a serious omission. Such a policy is required by both the Mental Health Act and HIQA standards. In developing a policy, managers should take account of our observations.

Evidence from our visits to Cappahard Lodge and inspection of case records:

There was a music therapist in the unit on two of the days we visited. The residents seemed to enjoy this and participated enthusiastically.

When one of the review team made a visit to the unit at short notice, there was a good effort on the part of staff to engage residents in activities. One staff member was playing dominos with some of the men. Women were getting their hair attended to.

There is a weekly programme of activities posted on the notice board. Residents can participate if able and if they wish. However, it appeared to be a single programme with little evidence of choice or individualization.

.

The unit has a sensory stimulation room with a variety of visual and auditory equipment and objects for touching and feeling. The sensory stimulation equipment was well used. The unit keeps good records of which residents used the equipment and it was good to see that several residents spent time in the room.

The unit organizes occasional outings and pictures of an outing a few months previously were on display. These outings appear relatively infrequent. We heard that the transport is only suitable for people who are relatively fit and mobile.

We were shown documentation that staff proposed to use on pooled activity levels. This had been devised by the occupational therapist but was not yet in regular use. The purpose of the tool to measure pooled activity is to decide, for each resident, the type of activity that would be of most benefit. This information would be used to develop an activity programme for the unit.

Individual care plans, as we have already observed, were based on tasks and problems rather than on need. Need for activation was not recorded in the care plans we examined

Art therapy is also available for residents who are able and who enjoy it.

The unit has an enclosed garden. Our visits were in January so it was not surprising that the doors to the garden were closed. On a visit conducted with minimal notice the previous summer, one of the review team observed residents using the garden facility.

Evidence from interviews:

Relatives were generally complimentary of efforts to provide activity

- “We find that he is always, even if he thinks he is, helping by brushing or doing something. In the painting and the drawing, he is always trying to do something, or he is always trying to help. I’d say he is very much involved.”
- “They gave them tambourines and then the room that they had for them, the relaxation, that was great. We felt we wanted to go in there ourselves.”
- (Regarding art therapy). “She does artistic work It looked very good, what she had on offer.”

One relative had a less positive view of activities and was critical of the use of TV and video

- “After X (a nurse that used to take residents for walks) left, I never saw anybody walking after that, even in the height of the summer. The garden outside, nobody was brought out, and I never saw any of them go for drives. The only thing I saw in the day room, and the staff used to complain about in themselves, was they used to put in the afternoon a video of Foster & Allen singing Danny Boy. It was enough to depress me to be honest. That was what I saw on the T.V. Another thing I noticed, they were all sitting around watching a particular programme, all the patients, and a nurse came in, didn’t ask the patients were they watching it or would they mind if she wanted to watch something, this was a nurse now working. She just picked up the remote control and changed her programme that was on. She didn’t even ask them. I found that horrifying, because they were watching a programme and nobody seemed to think they had a right to continue watching the programme.”

Recommended action:

We were impressed with attempts to provide meaningful activity with limited resources. The staff have good ideas for improving activity and we were impressed with good use of sensory stimulation. While the work on pooled activity is worthwhile, we think that some additional action would improve the level of activity.

- There must be a policy on activity. This must include a statement that all residents have individual activity specified in their multidisciplinary care plans, including the opportunity to spend time outside, including using the garden space and use of community facilities.
-

5.17 PALLIATIVE CARE

Is there a policy?

There is a policy on “Care of the Dying”

Is it adequate and being observed?

Evidence from reading the policy:

We thought this policy was thin, weak and failed to address issues of concern expressed by carers of people with dementia who die in care settings. Significant omissions were:

- The need for a single room to preserve privacy and dignity
- Development of palliative care expertise among staff
- Access to specialist palliative care advice
- Framework to make decisions about not offering resuscitation and to withdraw or withhold life-sustaining treatment
- Special techniques to relieve pain (patches, syringe drivers)
- Faith issues and cultural support (especially for anyone of non-Christian faith)
- Availability of overnight stay for relatives

- Bereavement support for relatives, including continued involvement in the unit if they wish

Evidence from our visits to Cappahard Lodge and inspection of case records:

There was no resident who appeared to be in the final stages of illness when we visited. We have not therefore had the opportunity to witness palliative care in action.

We reviewed the care of a very frail resident. When we saw her and reviewed her care plan, we were impressed with the quality of her care. Staff appeared to treat her with respect and dignity and her care plan dealt well with a wide range of physical health needs

We asked to see the case records of the last resident to receive palliative care in the unit. His care plan was good, with clear evidence that staff recognized when he was in pain and responded to it by giving appropriate pain relief. However, the notes recorded statements such as “appears to be in pain”. There was no evidence of the use of a tool to measure pain in a person with dementia who was unable to communicate his pain.

Evidence from interviews:

Relatives of a person who had died in the unit gave conflicting views of his care, especially the assessment and management of pain.

- “I felt X was in pain, but the people were seeing it as if he was aggressive or agitated, but he wasn’t. I just felt that he wasn’t able to communicate. (Relative A)”
- “He was so thin that even when you would move him in the chair like, you know, he would be crying out in pain.” (Did the staff give him enough pain relief?) “Oh yes, they did.” (Relative B)

Support for relatives does not end with death. Nursing staff and the GP told us that it was routine for staff to go to the funerals of people who died in the unit. A relative told us:

- “Staff from Cappahard came (to the funeral) and they brought a few of the patients that we knew.”

It was also good to hear that staffs keep in contact with relatives after someone has died.

- X – he's in the kitchen, in the laundry room, keeps saying to me "they're still asking for you". I said "I'll know when I am ready to go back over".

Staff appeared to us to be dedicated to the comfort of people who were reaching the end of life. They felt that they had the skills necessary to perform this task and that they could call on the skills of specialist palliative care services for extra advice and support, although this has not happened to date. However, few had any specific training in palliative care. A minority of staff knew how to operate a syringe driver and none had any knowledge of a specific pain assessment tool for people with dementia.

Our impression was that palliative care was carried out well in the unit despite the weakness of the policy. However, we noted some concerns from one relative. Improvements to policies and procedures would allow staff in the unit to demonstrate better that they provide good care for dying people.

Recommended action:

The policy on care of the dying needs to be substantially rewritten. The rewrite should take account of our findings. We recommend that a specialist in palliative care has input into the development of the policy. The policy should also address the recognition and management of pain in people with dementia.

5.18 SUDDEN DEATH POLICY

Is there a policy?

There is a policy on sudden or unexpected death that covers Cappahard Lodge

Is it adequate and being observed?

We thought the policy was adequate. It appears to have been written with particular regard to death by suicide, but the key aspects are appropriate to Cappahard Lodge. We were not able to assess whether it was observed.

5.19 RECORD KEEPING

Is there a policy?

There is a policy on recording clinical information. We found no policy on recording of non-clinical information. The HSE may wish to determine the need for a policy on this.

Is it adequate and being observed?

Evidence from reading the policy:

From reading the policy, we had no criticisms. The policy was well written, clear and covered all the important areas.

Evidence from our visits to Cappahard Lodge and inspection of case records:

- In general, case records were well maintained, easy to follow and up-to-date.
- All disciplines record information sequentially. There is no separation between medical and nursing recording. We commend this as best practice.
- There was very good recording of behavioural interventions, including clear reference to care plans.
- Emergency medical staff from Shannon Doc (out of hours) did not always write in the case records.
- Some clinical information, e.g. blood results and residents' weight were kept separately. This appears to contravene the policy which states clearly that all clinical information must be recorded in individuals' case records. We drew this to the attention of staff and they undertook to address this.

Recommended action:

To adhere to policy, all clinical information must be recorded in individual case records. The Area Executive should remind staff to adhere to the policy of recording information in individual records and ask Shannondoc to do likewise when called out.

5.20 RELIGION POLICY**Is there a policy?**

No

Is policy needed?

Yes. Such a policy is required by both the Mental Health Act and HIQA standards.

We saw no difficulty in providing religious services and support for the vast majority of the residents. When we visited, there were no residents from a religious or ethnic minority group. We were particularly interested in end-of-life care for people from a minority faith. Staff believed they would be able to access this but the lack of policy and guidance does not convince us that this would always be the case.

Evidence from interviews with Staff:

We heard of one incident where a member of staff made an inappropriate statement about a Jewish person:

- “(Member of staff) started talking to me about the woman’s husband and started telling me in a loud voice joking about the fact that the woman had been married and she says that her husband was very kind but he was a Jew and sure I have never seen a kind Jew in my life and she was saying this in front of the patient and she was being stereotypically racist as well as abusive to the woman.”

Recommended action:

There should be a policy on religion for the unit. This policy should cover cultural diversity and ensure that any possible discrimination is eliminated.

5.21 VISITING

Is there a policy?

Cappahard Lodge has a visiting policy.

Is it adequate and being observed?

Evidence from reading the policy:

Good points:

- The visiting policy encourages residents to maintain contact with family and friends.
- It encourages visitors to respect the privacy and comfort of all residents.
- The policy provides a framework within which to manage visitors in Cappahard Lodge.

Concerns:

- While policy states that visitors must leave at 9pm, staff allow relatives to stay later if the resident is very ill. We think this is appropriate and policy should allow flexibility here.
- The policy states that visitors must be courteous and respectful to residents, staff and other visitors at all times but has no corresponding policy on how staff should deal with visitors who behave disrespectfully.
- The policy does not state that the resident can choose who he/she sees and does not see, and that his/her wishes are respected and recorded.
- The policy is not clear on the resident's right to receive visitors in private. This would appear to be at the discretion of the nurse in charge.
- The reference to a "key relative policy" in the visiting policy is somewhat confusing.
- The visiting policy does not provide for relatives who wish to take residents off the unit.

Evidence from our visits to Cappahard Lodge and inspection of case records:

There were no notices displayed to alert the public to the policy provisions regarding:-

- The management of disrespectful behaviour.
- The banning of cameras and camera phones.

The visiting policy states that visitors are not permitted to walk through private bed areas. This is not enforceable because in some situations when visitors are permitted to visit residents in their bedrooms they must walk through private bed areas. Also some rooms are shared rooms so visitors visiting relatives in these rooms must intrude on other residents' private bed areas.

Evidence from staff questionnaire:

Some staff were of the view that:

- More private visiting areas should be provided
- More trips and visits out should be organised and this would include meals out for the residents.

Evidence from interviews with relatives:

One relative advised the review group that the facilities in Cappahard Lodge for visitors were bad in that there were no toilets for the use of visitors and she had to take her son out on the grounds to use the toilet. This same relative stated that she was given no information about visiting, visiting times or about any restrictions to visiting. She initially visited her relative in the bedroom then used to walk around the unit with him as he was restless and eventually visits were confined to the visiting area. During her visits she observed residents in various situations where their privacy and dignity was compromised.

Another relative described being made welcome on the unit during visits and being given tea by the staff. This relative described going on occasions to the resident's sitting room and becoming friendly with some of the residents over time. The nursing staff then stopped this and they were not allowed to go there anymore.

Another relative stated that she was given a newsletter but not an information booklet, and was made feel welcome when they visited Cappahard Lodge. She described visiting her husband in his bedroom and then in other areas in the Lodge where he engaged in activities such as painting, music and entertainment. She described the visiting arrangements as very flexible and accommodating.

Another relative stated he was happy with the visiting arrangements and was made very welcome by the nursing staff. He stated that he could visit day or night up to 9.00 p.m. and visits in the visiting area

Another relative stated that he was never given an information booklet about Cappahard Lodge but is always allowed visit when he turns up and he knows all the staff there. He is always made welcome there, and offered a cup of tea or coffee.

Recommended action:

- The visiting policy needs some amendments to address visiting times, areas and restrictions with provision for exceptional situations. Staff would benefit from guidance on dealing with conflict with visitors. This policy should be reflected in the information booklet for the unit.
 - The policy on key relative should be linked to the visiting policy as there is a great deal of commonality between both and the current situation can be a source of confusion/frustration for relatives.
-

5.22 KEY RELATIVE

Is there a policy?

Yes.

Is it adequate and being observed?

Evidence from reading the policy:

Good points:

- The policy recognises the need for families to be kept fully up to date of any adverse changes in a resident's condition.
- The resident chooses who they key relative is (i.e.) who he or she wishes to be the main contact for communication about his/her condition.

Concerns:

- The policy is unclear as it states firstly that the family members are asked to identify a key relative and later the policy states that the resident is asked to do this.
- It is unclear from the policy whether the key relative concept operates for the duration of a residents stay in Cappahard Lodge or is used only when a resident becomes unwell or their condition is unstable i.e. "the policy states that the key relatives' details will be kept at the front of the residents chart until their condition stabilises".
- The policy does not make provision for all nursing staff to provide general information on residents to all relatives.

Evidence from our visits to Cappahard Lodge and inspection of case records:

Nursing staff do give general information to relatives and are aware of the sensitivities of dealing with relatives particularly those of residents who are seriously ill. Also, there is evidence that the details of the key relative are kept at the front of the resident's chart.

Evidence from interviews with Staff:

Staff members (CNMIs) stated that where there is conflict or disagreement among relatives or families they would discuss the matter with the Next of Kin (NOK) as to "what kind of information they would like the staff to pass on" to other family members if and when they ring looking for information. The staff would discuss it with the Next of Kin first. There would appear to be some confusion here re NOK/Key relative.

Evidence from interviews with relatives:

One relative informed us that on one occasion when she asked a nurse what happened to her father that his head was bruised she was told "the NOK had been informed and it wasn't any of my business".

Another relative (NOK.) told us that if there was any change in her husbands treatment she was informed. “The Consultant would leave a message for her to call into his office”. Nursing staff would always keep her “informed about everything”.

Another relative (NOK) advised us that she was always contacted re her husbands treatment and condition. “We are always informed; we were never left in the dark”.

One relative (NOK) whose sister is a resident stated that he is never told about changes in her medications regime. “No they never disclose anything like that to me”. He stated that he has difficulty meeting his sister’s doctor and was told he would have to set up a special appointment for same. “I am more or less completely in the dark”.

Another relative speaking about his sister stated that he would not be notified about changes in her treatment.

Recommended action:

The key relative policy needs to be amended to clearly define the identity and roles of the key relative and next of kin. It should be combined with the visitor policy for the purpose of clarity and to avoid confusion for relatives and for staff. This should result in a more consistent approach from staff to sharing information with relatives.

5.23 COMPLAINTS

Is there a policy?

The unit has a policy on complaints. The policy seems to have a degree of interface with Trust in Care. As well as providing a view on the policy and procedure for responding to complaints, we examined the interface with Trust in Care, especially in relation to one specific complaint brought to our attention. At all times, we made it very clear to all the people we interviewed that we would not be examining the substance of any particular complaint but that our interest was in policy surrounding complaints and how this policy was being observed.

Is it adequate and being observed?

Evidence from reading the policy:

The policy gives a useful staged series of responses with expected timescales. In general, however, the policy was poorly written and needs a thorough overhaul.

There is a statement on the “Code of the policy” with no reference to the meaning of that phrase. The aim is a responsive service – this should be clearly stated at the outset.

The policy refers to “Your service your say” forms. These are available for residents and visitors to give their views. The policy is unclear and could be interpreted as suggesting that they are an alternative to making a written complaint

Roles and responsibilities – there is a statement that the complaints officer is involved in responding to verbal complaints. These are stated to be resolved locally. The policy seems inconsistent.

The policy refers to “complaints about colleagues” – this is confusing. Is it the staff member who is complaining? We suspect it refers to the staff member who receives a complaint about a colleague from a resident or visitor. If so, the policy should be clarified.

We noted that it was the role of the complaints officer to support colleagues who were the subject of a complaint. The policy should ensure that support for staff is separated from impartial investigation of a complaint. It should be the line manager’s role to provide support.

On our visits to the unit, we did not see anyone who had raised a complaint.

Evidence from interviews with relatives:

One relative had made several complaints about care in Cappahard Lodge. The first of these was treated as an expression of concern and a request for information. When the relative was not satisfied;

- “I continued to write and eventually wrote to the Local Health Manager and to the Mental Health Commission and they asked for the meeting with the Assistant National Director, and then I wrote again to another man, I think, it was because of that, that they decided then that they would look at – when I wrote about the bruising in July and about what the Ennis Hospital had told me again, I did get a letter back saying that there was bruising, they had no explanation, but didn’t deem it significant.”

Following this, the complaint was referred for a “Trust in Care” investigation. It is our understanding that there was a preliminary investigation only. This is intended to answer the question “could abuse have occurred?” It then appears that no further investigation took place because it was determined that abuse could not have occurred. We understand that the complainants were not satisfied with this response and that the Consumer Affairs Department is still dealing with this matter.

The relative told us that she did not receive a written acknowledgement of her complaint. However, we found written documentation of screening of a series of complaints. We found some confusion as to whether these were complaints or allegations of abuse. The relative told us:

- “I wasn’t accusing anybody of abuse and I have never said that, but once we started to meet and start writing and start asking, at the end of the day you know, I just wanted my father to get better care.”

The relative was given a copy of Trust in Care but not the complaints policy. We note that the definition of abuse contained in Trust in Care is very broad and includes neglect and poor professional practice as well as deliberate abuse. This can result in uncertainty about the application of the Trust in Care procedure and policy on complaints in individual situations.

None of the other relatives we saw had found cause to complain. Our comments on the operation of the complaints policy are therefore restricted to this one case.

In the case referred to above, the Consultant gave us his views. It was clear that he was unhappy with the way the complaint was handled.

- “I have spent the best part of, when I counted up the hours, nearly two years full time work dealing with mainly the overspill and fallout of one specific set of complaints.”

When asked about support during the process, the Consultant replied:

- “Absolutely and unfetteringly none.”

Evidence from interviews with Staff:

We pursued the management of complaints with the Area Executive. The first issue was to identify who was the “complaints officer” for Cappahard Lodge. Despite asking this several times, we still do not have a clear understanding. The Area Manager told us that it was the Assistant Director of Nursing. When we pursued this through examples of complaints, this appeared not to be the case. The Area Manager appears to try to coordinate all the complaints and as a result can sometime spend up to 90% of her working week on this. This seems an inappropriate use of a senior manager’s time.

We also pursued the interface between complaints and Trust in Care. We clarified with the Area Executive that, where a list of complaints include an issue that might suggest abuse, there should be a separation of which elements of the complaint should be referred for Trust in Care investigation. A member of the Area Executive told us:

- “If it is quite clear after meeting the complainant, that they fall within separate category, if complaint X, Y and Z is about facilities, quite clearly that falls within the scope of the national complaints policy. The elements that refer to abuse are where there is an allegation around abuse; they are dealt with under the “Trust in Care”. There were 15 agreed complaints in all. However, advice taken was that the preliminary screening and process from “Trust in Care” would be used. That would be the framework.”

This differs from the Consultant’s understanding. He told us:

- “I pointed out immediately when I heard that did not seem appropriate for the specific reason that Trust in Care as I read it and understand it is specifically designed to deal with allegation that somebody abused this person.”

The lack of clarity on the interface between the two processes left staff and the complainant in a state of uncertainty, the complainant was dissatisfied with the process and the problem continued to escalate. There are lessons to learn from this. Our reading of the most recent HSE policy on complaints (dated December 2006) makes no reference to the possibility of confusion at the interface with Trust in Care.

We clarified from the Area Executive that all “Your service, you say” forms were received by the central customer service office and reported to the area manager.

Recommended action:

- The HSE must examine the interface between complaint handling and investigation of abuse under Trust in Care and provide clear guidance for managers and staff and clear information for complainants.
 - The Area Executive for Clare Mental Health Services must review the procedures for handling complaints, identify and train appropriate individuals to be complaints officers and delegate the responsibility from the Area General Manager, whose role should be restricted to “signing off” complaints and assuring the quality of the process.
-

5.24 ABUSE

Is there a policy?

“Trust in Care”, used across the HSE, is the main document that guides management of allegations of abuse. The unit also has a policy on allegations of abuse made against staff.

Is it adequate and being observed?

Evidence from reading the policies:

Both policies contain strong statements about the unacceptable nature of abuse. This should increase public confidence that allegations of abuse will be taken seriously and thoroughly investigated.

Trust in Care states that anonymous complaints cannot be investigated. While full investigation may not be possible, preliminary screening to determine if abuse could have occurred would be useful to address potentially unsafe situations where residents cannot be guaranteed safety from abusive practices and staff may be vulnerable to unfounded allegations

There is significant overlap with other policies, notably complaints (see above) and disciplinary policies. In reading these policies, the interface and overlap was not clear. The local policy on allegations of abuse was particularly unclear in that it mentioned a host of other policies and procedures without explaining the overlap and any potential flow of an individual case from one procedure to another

Policies were generally clear about a duty to report abuse. However, there is no reference to protected disclosure of information to, for example, a professional organisation or to the Mental Health Commission. The Health Act (2004) as amended by the Health Act (2007) covers this in some detail

Evidence from visits to the Unit:

From visits to the unit we found no evidence of any practice or attitude that would indicate abuse

Evidence from staff questionnaire:

We asked staff anonymously whether they would be confident to report abusive behaviour by colleagues. The answer was a unanimous yes. Some staff would, dependent on the severity, confront the colleague in the first instance. However, we were especially pleased to see that all staff believed that their concerns would be taken seriously by management.

Evidence from interviews:

Nobody had witnessed direct abuse of resident. One relative raised concerns about practices that infringed the privacy and dignity of residents. This included bathing and shaving in front of other residents and the use of commodes in inappropriately public places.

This relative and the Consultant referred to allegations of abuse made but then not formally attested to by student nurses in the past. It is beyond the scope of this review to make comment on the specifics of these allegations. Service managers and educational supervisors must work together to ensure that students who raise concerns receive appropriate support. We are satisfied that staff currently feel confident to report abuse and that the culture of the unit neither supports nor condones abusive practices.

Recommended action:

- The Health Act (2004) as amended by the Health Act (2007) allows for protected disclosure of information. The HSE should revise Trust in Care to reflect this.
 - As per our comments on complaints, the HSE must give greater consideration to the interface between policies on abuse and complaints.
-

5.25 STAFFING POLICIES

Is there a policy?

Yes Cappahard Lodge has policies on staffing.

Are they adequate and being observed?

A number of policies exists which come under the broad heading of staffing. They include recruitment, retention, organisational structure, grievance and disciplinary.

Evidence from reading the policies:

Good points:

- The policies in general are clear and concise.
- Recruitment policies and procedures are based on current legislation and best practice.
- All staff have written job descriptions and written terms and conditions of employment.
- Recruitment is carried out under the principles as set out in the Code of Practice which applies to the recruitment of all staff in the H.S.E.

- Staff retention is promoted through:-
 - The encouragement of personal and professional development.
 - The sponsorship of staff in continuing education and professional development.
 - An active in service Training Programme,
 - Practice development programmes and continuous promotional opportunities for staff. (8 staff are currently studying for graduate Diplomas).

In relation to the grievance and disciplinary policies:-

- Clear processes are set out.
- They allow for some flexibility
- They are constructed to allow, “even handedness” and appear fair to all parties.

Concerns:

- The involvement of H.R. in the grievance policy should be reviewed; perhaps their advice should be sought at an earlier stage in the process.
- Disciplinary principles need review as many of them are part of operational disciplinary procedure especially the sections related to “additional sanctions”.

Evidence from staff questionnaire:

The staff responses included:

- Health Care assistants would be of benefit to the unit.
- Rostering systems should be reviewed.
- Some staff are not confident with the management of risk on the unit, stating that their knowledge and experience is not always recognised.
- A lot of staff have not had in-service training in the following areas:-
 - Managing incontinence.
 - Assessing and managing falls.
 - Assessing and managing behaviour problems.

Evidence from interviews:

The Organisational Chart for Cappahard Lodge shows the Assistant Director of Nursing as the person responsible for nursing and related issues in the Lodge and is accountable to the Director of Nursing and the Clare Mental Health Service Area Executive. This was confirmed by

the Executive who advised that “the overall responsibility for day to day activity in the nursing area rested with the A.D.O.N.” for Cappahard Lodge.

At interview the A.D.O.N. for Cappahard Lodge stated that:-

- The A.D.O.N. does not have any responsibility for staffing in the unit.
- The A.D.O.N. finds it difficult to actually look at care issues when she cannot look at the staffing.
- The A.D.O.N. does not have influence over the day to day running of the unit.
- The A.D.O.N. does not have the autonomy to implement change in pursuit of best practice.
- In the A.D.O.N.’s opinion it is the Executive as a collective group who is responsible for the implementation of the nursing philosophy in Cappahard Lodge.
- The A.D.O.N.’s opinion is that the Executive is the “responsible person” who “leads” on risk management in Cappahard Lodge not the A.D.O.N.
- The A.D.O.N. advised the committee that she has a number of staff who are becoming highly skilled in the area, but she has no influence over their retention in that specialist area, “They could be moved tomorrow”. This is due to a historical rostering system which she cannot change despite making proposals. “People can become disillusioned quickly when skilled staff are moved out of the area”.

The A.D.O.N.’s view was that people who are interested in working in Cappahard Lodge and who are interested in developing their skills in that specialist area should be allowed stay, but the trade unions have objected to any change in the rostering system. “It is set in stone”.

The problems with staff retention in Cappahard Lodge are due more so to the staff being rostered in and out of the unit than to any reluctance upon the part of staff to work there. In fact people really do not have the choice to work in an area of their preference.

The A.D.O.N. recognises the need for skill mix and particularly the introduction of the Health Care Assistant Grade. The introduction of this grade would free up nursing staff to undertake more specialist interventions with clients/residents. While there have been discussions about this the matter has not been progressed.

In relation to Disciplinary/Grievance issues in Cappahard Lodge the A.D.O.N. would not generally deal with these it would be the Director of Nursing because the A.D.O.N. has very little knowledge of past behaviour or records of staff passing through Cappahard Lodge. The A.D.O.N. has very little involvement in Disciplinary or Grievance matters and finds this disempowering.

This view would appear to be at variance with that of the Area Executive who advised the review committee that disciplinary and grievance issues are dealt with through the line management structure i.e. Firstly by the CNMII and then the A.D.O.N. and lastly to the Director of Nursing. "In the area of discipline most work performance issues are dealt with at first level".

The Executive did advise that there are difficulties around the rostering of staff. Attempts to change same have been resisted by Trade Unions and the current system has a historical basis rather than a client focussed one.

The CNM II Group at interview, advised the Committee that the off duty system has a negative effect on the key worker system. The lack of continuity of staff makes it very difficult to operate same. In some cases the Key worker system was designed around the roster more so than being designed around the clients.

CNM IIs don't have control of staff coming in or out, and from a continuity of care aspect a fixed roster would be excellent.

Recommended action:

- The role and responsibilities of the post of A.DO.N. need to be clarified with particular reference to:-
 1. Responsibility for the overall day to day operation of the unit and the limits of authority to implement change in pursuit of best practice.
 2. Responsibilities for discipline and grievance issues.
 3. The leadership role in relation to the implementation of nursing philosophy in Cappahard Lodge.
 4. Responsibility for risk management in Cappahard Lodge.

- The current rostering system should be reviewed a matter of urgency to facilitate:-
 1. The retention in Cappahard Lodge of staff who are highly skilled in the area of Psychiatry of Old Age.
 2. The retention in Cappahard Lodge of staff who are interested in working and developing their skills in this specialist area.
 3. Greater choice for staff to work in areas of their preference.
 4. Greater continuity of staff which would allow for more effective operation of the key worker/primary nurse system in Cappahard Lodge.

 - The introduction of skill mix to Cappahard Lodge. The introduction of the Health Care Assistant grade staff to Cappahard Lodge would bring immediate benefits particularly from the perspective of freeing up nursing staff to undertake higher level nursing intervention with residents.

 - The provision of an active in-service education/training programme to staff in Cappahard Lodge to include:-
 1. Managing incontinence.
 2. Assessing and managing falls.
 3. Assessing and managing behaviour problems.
 4. Palliative care.
-

5.26 THE USE OF CLOSE CIRCUIT TV

Is there a policy?

Yes.

Is it adequate and being observed?

C.C.T.V. is not in use in Cappahard Lodge. A system has been installed in Cappahard Lodge and the cameras are clearly visible, but it is not in operation.

The committee has been advised that there are no plans to put the system into use.

Recommended action:

- The existence of cameras in Cappahard Lodge may cause some confusion to residents, and visitors. Notices should be erected to indicate that C.C.T.V. is not in use.
 - Should the C.C.T.V. system be activated in the future then the C.C.T.V. policy should be reviewed. It should be developed in line with a number of statutory regulations and guidelines. Particular cognisance should be taken of Article 8 of the Human Rights Act 1998 which protects the rights to respect for privacy and family life.
-

5.27 CORRESPONDENCE AND COMMUNICATIONS

Is there a policy?

Yes, a policy on correspondence and communications exists.

Is it adequate and being observed?

The policy is very brief but confirms that

:

- Post received or sent by residents may not be intercepted or withheld in under any circumstances.
- Electronic mail is treated as per written correspondence
- Public phone facilities are available to residents.

The policy also states that as a protection of the rights and privacy of resident's camera phones and recording equipment are not permitted in the centre.

We heard of no concerns about residents' ability to communicate. In the staff questionnaire, we asked "if a relative or friend asked you to stop a resident from phoning or sending mail, what would you do?" None of the respondent stated that they would prevent a resident from doing so.

Recommended action:

The information booklet for residents and visitors should assert the resident's right to unrestricted communication.

5.28 FOOD SAFETY POLICY**Is there a policy?**

A Draft Food Safety Statement for Cappahard Lodge was provided to the Committee which confirms that a unit specific Food Safety Manual (HACCP) has been drawn for the centre.

Is it adequate and being observed?Evidence from reading the policy:

The Food Safety Statement outlines that the Clare Mental Health Services adopt a strategic approach to Food Safety management which is based on NSAI IS:340:2007 & IS:22000:2005 with the aim of conducting its operations in so far as is reasonably practicable to ensure the highest standards of Food Safety and Hygiene.

The statement confirms that St Joseph's Hospital Central Catering facility supplies by customised temperature controlled transport 3 hot/chilled meal services per day to Cappahard Lodge for the consumption of residents. Cappahard Lodge has an appropriately equipped receiving kitchen to fulfil this function. The daily staffing structure for unit includes 4 attendants 2 of whom are assigned to catering duties and 2 to housekeeping duties.

The Food Safety Manual is divided into a number of sections – internal policies, internal procedures; internal records and forms; internal process flows; external documents and external records. This manual opens with a policy statement and all subsequent sections provide clear guidance for relevant staff.

The Committee was advised that a HACCP Co-ordinator has been appointed in Clare to provide for current and future compliance in the area of Food Safety. The Co-Coordinator provides Information, training and supervision for employees to obtain the highest possible standards of food hygiene. It is care group policy that attendant staff together with unit nursing staff involved in food safety attend basic food hygiene training. The HACCP Co-ordinator also meets with management on a regular basis. It was also made clear to the Committee that the Environmental Health Service also plays a role in food safety and undertakes on site inspections at Cappahard Lodge.

Recommended action:

The Draft Food Safety Statement for Cappahard Lodge should be completed and approved as soon as possible and that ongoing training in food safety should be provided for all relevant staff to include training in food nutrition.

5.29 HEALTH AND SAFETY AND RISK MANAGEMENT POLICIES

Is there a policy?

The HSE introduced a new Corporate Safety Policy Statement in October 2006. The policy commits the HSE to the provision of safety, health and welfare in the workplace through the implementation of an integrated safety management system that is consistent with current legislative requirements. The Corporate Statement is supported by ancillary statements for each of the major divisions of the HSE including the PCCC Directorate.

The Corporate Safety Statement acknowledges the links with Risk Management and the HSE Mid Western area published a Risk Management Strategy in 2005 the stated purpose of which includes:

- The identification of roles and responsibilities for managing risk
- The improvement of coordination and integration of healthcare risk management.

Is it adequate and being observed?

Evidence from reading the policy:

Within the PCCC service each service location including Cappahard Lodge is required to have a Health and Safety Statement as a direct subset and consequence of the 2006 Corporate Safety Statement. A Health and Safety Statement for Cappahard Lodge in conjunction with the HSE Corporate Safety Statement was furnished to the Committee in June 2008.

Evidence of interviews with Staff

There is a risk management policy for Cappahard Lodge It states that all incidents, no matter how trivial, are to be reported to line management and signed by a Clinical Nurse Manager or the Assistant Director of Nursing. The Regional Risk Advisor provides feedback. The Assistant Director of Nursing told us that she would identify and discuss patterns with the Risk Advisor. She also told us that there was no formal mechanism for feedback to staff. Although she said this was done informally, the Clinical Nurse Managers told us that they received little feedback on these reports. From staff questionnaires, we learned that some staff are not confident with the management of risk on the unit and stated that their knowledge and experience was not always recognised.

While the Health and Safety statement is comprehensive running to some 60 pages, its late development (May 2008) and its submission to the Committee in June 2008 as the Committee was completing its work has meant that a full review of the adequacy of the Statement has not been undertaken. The Committee is conscious however of new and ongoing initiatives in the area of risk management by the HSE and is satisfied that this aspect of service will be subject to regular and significant attention and review across all HSE services into the future.

Evidence from visits to the Unit

From our visits to the unit, we observed that scalding hot water emanated from a hot water tap in a bathroom. We thought this was a serious risk to residents and brought it to the immediate attention of staff.

Staff also reported to us that the heating system was unreliable and could result in parts of the unit becoming either too warm or too cold. We were advised by the Area Executive that money had been spent to upgrade the heating system. This matter needs to be kept under review.

Recommended action:

- The Safety Statement for Cappahard Lodge needs to be reviewed on an ongoing basis to take into account any change in the status of the facility including its possible designation as an Approved Centre under the Mental Health Act 2001.
 - There must be greater clarity over responsibilities for risk management in Cappahard Lodge and for learning from incident reports and trend analysis. It is likely that this will be covered by a new national framework for integrated quality and risk management
 - There must be a maintenance schedule for health and safety work, especially to ensure the safety and effectiveness of heating and plumbing
-

5.30 LEGAL STATUS OF RESIDENTS

In reviewing the Policy and Procedures governing care of residents of Cappahard Lodge, we identified issues of restriction and deprivation of liberty. We acknowledge that these are matters primarily in the legal domain and accordingly we are not offering a definitive view on the legal position.

Article 5 of ECHR prohibits deprivation of liberty but accepts that there may be occasions where a person with a mental disorder may require to be 'detained'. The Article itself is brief. It permits the 'detentionof persons of unsound mind', provided this is both 'lawful' and 'in accordance with a procedure prescribed by law". The person who is detained must have the right of speedy access to a court or tribunal to appeal against the detention under article 5(4) of ECHR.

In the course of our visits and interviews, we noted several instances where residents stated a desire to leave and were prevented from doing so. It appears that staff in Cappahard Lodge have no legal procedure other than detention under mental health legislation. As it is not an approved centre, this would have necessitated transfer to another unit. We note the view of the Mental Health Commission that Cappahard Lodge should be an approved centre. However, care homes

for people with dementia face problems like this on a regular basis. Making them all approved centres for the purposes of detention under mental health legislation is impracticable.

We make no judgement on whether it was right or wrong for staff to prevent residents leaving the unit. It is clear that they acted in good faith and they did what they believed to be in the best interests of the residents. It appears that they were acting under principles of necessity and duty of care in the absence of adequate legal procedures. We are satisfied that the staff did the best they could in an unsatisfactory legal situation. The wider legal issues need a national solution.

Recommended action:

The HSE should take legal advice on the legal basis for restricting/ depriving residents of liberty, having regard to the European Convention on Human Rights and the jurisprudence of the European Court of Human Rights. Depending on advice received, the HSE may need to notify the Government of any legal concerns or legislative change that may be necessary. The Government may wish to bring forward legislation in line with the report of the Law Reform Commission on intervention where an adult lacks capacity.

Section 6: Summary of conclusions and recommendations

6.1 Introduction

Our overwhelming impression of Cappahard Lodge is that it is a good facility offering a good quality of care. Residents and relatives spoke highly of the care provided. The one relative who expressed concerns subsequently stated by way of submission to the committee that she believes the care has improved since her experience at Cappahard Lodge. Staff were very positive about their roles and we believe that on going work on culture and attitudes is having a positive effect on care and will continue to enhance the standard of care in the facility. There are some deficiencies in the policy framework, overall governance and in some aspects of the provision of care. We therefore have recommendations and suggestions for improvement.

We offer recommendations to Clare Mental Health Services and to the Health Service Executive more generally. The recommendations are under the relevant categories;

1. Governance framework
2. Service Planning
3. Rights and safety
4. Clinical Care
5. Support for clinical Care

6.2 Recommendations to Clare Mental Health Services

Governance framework

1. We recommend that the Area Executive develops a standard template for all written policies, procedures and guidelines
2. It is the responsibility of the service to ensure that their policies and guidelines are quality assured prior to publication and distribution. From a continuous quality improvement perspective ongoing and active review of policies and guidelines should take place.

Service planning

3. If Cappahard Lodge became a specialist dementia care facility, it would need to serve a larger catchment population than it does at present. This would need a major strategic examination at regional level by the HSE. For the foreseeable future, we believe that the unit will continue to serve a mixed client group. We urge all parties to accept this and to work together to meet the diverse needs of the residents of Cappahard Lodge.
4. In line with our comments about clarity over the purpose of Cappahard Lodge, the admission criteria need to be reviewed, taking account of the projected need within the catchment population, including the needs of younger people with dementia.
5. The Area Executive should continue to review the mix of residents in Cappahard Lodge and other facilities in the county to achieve the best geographical and functional balance in provision of continuing care.

Rights and safety

6. Prospective residents and carers should have written information on the unit. We recommend that the unit produces a written brochure/information leaflet. This should include information on care provided, visiting arrangements, individual rights (including the right to communicate), other general operational issues, enquiries and routes for expressions of concern and complaints.
7. Residents at Cappahard Lodge should be identifiable to staff through, as a minimum, the use of photographs placed on their medical file. Any additional means of identification should be achieved in partnership with the resident/relative and done in the best interests of the resident.
8. Cappahard Lodge must have a policy on privacy and dignity. These needs to address:
Structural issues (we understand that there has been some progress here):
 - The provision of fixed screening / partitioning in shared rooms.
 - A move to single occupancy rooms where possible. The current laundry storage should be relocated and the space converted to increase single room provision.
 - The provision of a canopy type structure at the front entrance to Cappahard Lodge.
 - The provision of blinds / screens on all external windows and doors (now provided).
 - The completion of renovations to toilets to provide privacy to residents. This will be achieved through the provision of a lobby onto which toilet doors open. Toilet doors should also be fitted with a locking mechanism which can be over-ridden by staff and all toilet doors should open outwards. The provision of a call system in toilets.

Individualisation:

- The provision of personal items such as pictures, photos and mementos in individual rooms.
- A move away from the use of bulk products i.e. shampoos, soaps etc.

Choice:

- The increased involvement of residents (and where appropriate their relatives) in their individual care planning. (The person centred care approach which is being introduced will help achieve this objective).
- The provision of greater choice to residents in relation to meals. This can be achieved through the introduction of a menu card system where residents can choose from a set menu each day. The issue of staff being prohibited from preparing snacks for residents should be re-examined in order to promote the concept of choice and normalisation.

Clinical care

9. There should be a fundamental review of care plan documentation and process, underpinned by a policy statement and by the values of person-centred care. Needs assessment and life stories are important parts of care planning.

10. Care plans should be multidisciplinary. They should be informed by assessments from all professionals involved in the person's care. Care plan reviews should involve all disciplines, the resident where possible and the nearest relative(s). The primary nurse/key worker must have the responsibility for organizing care plan reviews, and keeping relatives informed and involved.

11. As a matter of urgency, the issue of primary medical responsibility needs to be clarified. If, as it appears in practice, there is a shared care model, this should be clarified in a written protocol. Depending on the future status of the unit, it might be worth examining a different model of physical health care input from the GP rather than the GMS arrangement that exists at present. Our view is that it would be preferable for the Consultant to have primary medical responsibility as this would help to resolve other difficulties surrounding regular examinations and reviews.

12. The unit needs a policy on physical health care. This should include regular (no less often than annual) physical examination, health promotion work and action to help people reduce smoking and facilities to ensure that no non-smokers are exposed to passive smoking.

13. The Consultant must have a regular fixed commitment to the unit. The difficulty in doing so because of workload must be resolved between the Consultant and the Area Executive. Ideally, the GP should be present for at least some of these meetings to facilitate good

communication. The need for such a commitment is independent of the uncertainty as to the purpose of the unit but is dependent on resolving the issue of primary medical responsibility. (We understand that the Consultant now has a regular fixed commitment).

14. The unit has shown us evidence of very good practice in behaviour management. We recommend that this is incorporated into a broader policy on managing behaviour that staff find to be a challenge.

15. The policy on care of the dying needs to be substantially rewritten. The rewrite should take account of our findings. We recommend that a specialist in palliative care has input into the development of the policy. The policy should also address the recognition and management of pain in people with dementia.

16. The policies on medication prescribing, administration and recording of errors are generally good. The Area Executive should consider some minor amendments and consider combining them into one document. This should include guidance on covert medication. Limited list prescribing for minor ailments should be within the competence of appropriately qualified nursing staff. We would encourage progress towards this

17. Much prescribing is done by the GP. He is not an employee of the unit but we consider that he should follow the prescribing policy. Prescribing audits, especially of generic versus proprietary prescribing, would be worthwhile.

18. Managers must develop a policy on food and nutrition. This policy must cover the points raised in this report

19. The Draft Food Safety Statement for Cappahard Lodge should be completed and approved as soon as possible and that ongoing training in food safety should be provided for all relevant staff to include training in food nutrition.

20. There must be a policy on activity. This must include a statement that all residents have individual activity specified in their care plans, including the opportunity to spend time outside, including using the garden space and use of community facilities.

21. To adhere to policy, all clinical information must be recorded in individual case records. The Area Executive should remind staff to adhere to the policy of recording information in individual records and ask Shannondoc to do likewise when called out.

Support for clinical care

22. There should be a policy on religion for the unit. This policy should cover cultural diversity and ensure that any possible discrimination is eliminated.

23. The visiting policy needs some amendments to address visiting times, areas and restrictions with provision for exceptional situations. Staff would benefit from guidance on dealing with conflict with visitors.

24. The key relative policy needs to be amended to clearly define the identity and roles of the key relative and next of kin. It should be combined with the visitor policy for the purpose of clarity and to avoid confusion for relatives and for staff. This should result in a more consistent approach from staff to sharing information with relatives.

25. The Area Executive for Clare Mental Health Services must review the procedures for handling complaints, identify and train appropriate individuals to be complaints officers and delegate the responsibility from the Area Manager, whose role should be restricted to “signing off” complaints and assuring the quality of the process.

26. The role and responsibilities of the post of the A.DO.N. need to be clarified with particular reference to:-

- Responsibility for the overall day to day operation of the unit and the limits of authority to implement change in pursuit of best practice.
- Responsibilities for discipline and grievance issues.
- The leadership role in relation to the implementation of nursing philosophy in Cappahard Lodge.
- Responsibility for risk management in Cappahard Lodge.

27. The current rostering system should be reviewed a matter of urgency to facilitate:-

- The retention in Cappahard Lodge of staff who are highly skilled in the area of Psychiatry of Old Age.
- The retention in Cappahard Lodge of staff who are interested in working and developing their skills in this specialist area.
- Greater choice for staff to work in areas of their preference.
- Greater continuity of staff which would allow for more effective operation of the key worker/primary nurse system in Cappahard Lodge.

28. We recommend the introduction of skill mix to Cappahard Lodge. The introduction of the Health Care Assistant grade staff to Cappahard Lodge would bring immediate benefits particularly from the perspective of freeing up nursing staff to undertake higher level nursing intervention with residents.

29. We recommend an active in-service education/training programme to staff in Cappahard Lodge to include:-

- Managing incontinence.
- Assessing and managing falls.

- Assessing and managing behaviour problems.
- Palliative care.

30. The Safety Statement for Cappahard Lodge needs to be reviewed on an ongoing basis to take into account any change in the status of the facility including its possible designation as an Approved Centre under the Mental Health Act 2001.

31. There must be greater clarity over responsibilities for risk management in Cappahard Lodge and for learning from incident reports and trend analysis. It is likely that this will be covered by a new national framework for integrated quality and risk management.

32. There must be a maintenance schedule for health and safety work, especially to ensure the safety and effectiveness of heating and plumbing

6.3 Recommendations to the Health Service Executive West

33. We accept that there are limits on resources for provision of health care. The residents of Cappahard Lodge need access to service for eyesight, hearing and foot care in the same way as any older person in the community has. There are some health risks that are greater in older people with mental illness, especially dementia. We therefore make recommendations to the HSE in relation to what we found in Cappahard Lodge, while being mindful that the same recommendations could apply to other facilities for the care of older people with mental illness.

- Dietetic and speech and language therapy input should be available for older people with mental health problems in Cappahard Lodge. These inputs would lower the risk of poor nutrition and choking.
- In our opinion, residents in Cappahard Lodge have a specific need for physiotherapy input. The HSE should determine the need for such input as part of a strategy to reduce the risk of residents falling and sustaining serious injury.

6.4 Recommendations to the Health Service Executive (Corporate)

34. The HSE must examine the interface between complaint handling and investigation of abuse under Trust in Care and provide clear guidance for managers and staff and clear information for complainants.

35. The Health Act (2004) as amended by the Health Act (2007) allows for protected disclosure of information. The HSE should revise Trust in Care to reflect this.

36. The Interim Guidelines on PPP accounts be updated and finalised as soon as possible and the HSE should examine arrangements whereby patients and relatives could be advised to seek legal and financial assistance at the earliest possible stage of diagnosis of a progressive debilitating illness such as dementia.

37. The HSE should take legal advice on the legal basis for restricting/ depriving residents of liberty, having regard to the European Convention on Human Rights and the jurisprudence of the European Court of Human Rights. Depending on advice received, the HSE may need to notify the Government of any legal concerns or legislative change that may be necessary. The Government may wish to bring forward legislation in line with the report of the Law Reform Commission on intervention where an adult lacks capacity.