because they were dependent on a place becoming available elsewhere. This was unfortunate as the wait was very frustrating for residents and staff, and the clinical state of some residents seems to regress a little as a consequence. Since their discharge these people have remained dependent on help and support from staff to varying degrees. At first this was provided by staff of the hostel ward but when the unit closed a support team was established in order to continue with this work (Colgan & Bridges, 1990).

Concluding comment

Although High Elms was not an ideal building as a hostel ward, the majority of patients admitted were able to benefit from the form of rehabilitation provided by its staff. Those who moved to the more homely purpose-built Anson Road Project have made further progress. From our experience the hostel ward continues to have an important place within the spectrum of services needed for people with chronic psychiatric disorders. However, it has its limitation, particularly with regards to the management of some behaviourally disturbed people. It has also proved to be an inappropriate form of care for those who are against being there. Unfortunately patients returning to hospital on a permanent basis had to join other long-stay patients on acute admission wards because of the lack of more appropriate hospital-based facilities for them (Wing, 1990).

References


Are your casenotes perfect?

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Working for Patients (1989) demonstrates the Government's intention to "encourage all Royal Colleges to make participation in medical audit a condition of a hospital unit being allowed to train doctors", suggesting this may also become a requirement for psychiatric trainees. The Psychiatry Department at Fazakerley Hospital moved into the rather uncharted territory of clinical audit with monthly unit audit meetings in 1989. At each meeting randomly selected cases are reviewed and data presented which are relevant to clinical practice on the unit. The majority of topic audits have been presented by trainees with support from consultants. Most Colleges agree that casenotes should be available for scrutiny (Warden, 1988). Consequently I undertook a casenote audit.

The "perfect casenote" should serve four main functions: informative – containing patient data and chronological details of events; legal – being the only written document recording the doctor's management of an individual case; communicative – enabling transfer of information between and/or within specialties, professionals and other hospitals; and storage – storage of information for future reference.

The study

The audit was carried out in the psychiatric in-patient unit of a district general hospital with 125 acute beds (approximately 15 beds per consultant). Disciplines incorporated were general adult psychiatry and functional psychogeriatrics, reflecting the practice of 20 doctors from consultant to SHO.

Four casenotes were selected blind from each ward by nursing staff. Duration of admission ranged from
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Suicide

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In an attempt to discover what can be learnt from records kept on suicide victims, all data collected by one health district about suicides occurring in patients in close contact with psychiatric care over four years were examined.

These comprised 12 in-patients, six recently discharged patients, and four patients in close contact with the CMHT. They were treated by eight different consultants and CMHTs. No one team had an excess of deaths.

In this district, as in many others, there is a policy that following a suicide, the care team should meet as soon as possible to review the case. The stated aim of this meeting is to offer staff support and constructive self-criticism. Following this a report is sent to the Mental Health Unit Manager. An examination of the reports of 22 suicides (certified as such by the Coroners’ courts) revealed that in all cases the care plan was seen as “appropriate”. Only six cases had been recognised as “at risk of suicide”, that is in most cases the risk had been considered low and ongoing. Although all patients had had previous contact with the psychiatric services, often over a long period of time, in only three cases was any attempt made to suggest why the suicide had occurred now. In only six cases were recommendations for change made. These all concerned measures to increase the supervision of the patient by the care team.

While it is impossible to say whether or not these written reports are a reasonable reflection of what was said or thought at the time, they are the only documentary evidence of the cases that are kept and can be studied. They were produced following the mental health team reviews and thus must represent a consensus view on how the case was seen. Private thoughts and reflections always remain so. Thus although the individual may have learnt something from the suicide no-one else will have access to that new understanding. Learning from personal experience cannot be the best way to increase knowledge about the risk factors for suicide. Is it reasonable to expect more useful information?

We are members of the ‘caring professions’. The unexpected death of a patient leaves all staff to a greater or lesser extent shocked and distressed.

We know from work with bereaved relatives (Murray Parkes, 1985) that grief is complicated when a death is unexpected, inexplicable, and when the relatives in some way feels responsible. One way to help staff through the grief is to attribute the suicide to within-patient factors, i.e. his/her illness, and to absolve everyone that all possible steps had been taken. While such statements cannot be construed as constructive self-criticism, they may be absolutely essential at the time to enable staff to continue working with an often difficult patient/client group.

Placing the problem solely with the patient can reassure staff that their judgement was correct, and their caring skills remain intact. Such statements may also be what many people want to hear. Many professionals are uncertain about their job security as mental hospitals close and units are relocated in the community. Managers are fearful of litigious relatives and relatives themselves may feel that the professionals’ judgement “nothing more could have been done” absolves them from any guilt.

The danger is that nothing new is learnt. Many years of research have produced good epidemiological information about groups of patients at risk, but are of little use in defining individuals at risk (Hawton, 1987). Goh et al (1989) recently called for more research into interpersonal and environmental aspects of suicide. This information can be given only by those people who knew the patient well. It can be collected only if the informants can recall and discuss their memory of their patient and their interactions.

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Cunningham