

Correspondence

Effects of ward closure on patients

DEAR SIRS

Recently a mixed, predominantly female, long-stay/rehabilitation ward with which I was involved was closed and the patients distributed into empty beds on other wards around the hospital—not an unusual occurrence in these days of 'Care in the Community', the decreasing in-patient population of psychiatric hospitals and part of the 'Management of Change'. This particular closure, however, was made more traumatic for the patients in that no warning or preparation was given prior to the week the moves were implemented. This was because neither the ward nursing staff nor the medical team involved with the ward were given advanced warning themselves. There was therefore no opportunity to discuss care and future plans with the staff who would now be looking after these patients. There was also a hiatus from the medico-legal point of view as to who was the consultant responsible for the patients during the time between their transfer and the eventual agreement of the consultants on whose wards they had been placed, with no prior consultation or agreement, to take over their care.

The patients, six men and 18 women, were distributed in groups of one to six, to nine different wards. On the day the closure was implemented both the sister and charge nurse were on days off. Staff and patients were crying together—hardly a therapeutic environment. In the six weeks since closure, the effects on the patients have been as follows:

One patient, already seriously ill before the move, died.

Another took his own discharge rather than change wards.

Ten patients accepted the change of environment with no obvious problems. One of these is said to be improved behaviourally in her new setting.

Five patients showed a deterioration in behaviour and condition which have settled with the appropriate treatment.

Three patients are still deteriorated to a level below their previous functioning. One of these, an elderly subnormal lady, had to be physically assisted from her original ward as her distress at the change was so intense.

A group of four men awaiting discharge to a MIND hostel in the community were transferred to a male ward together. Their psychiatric condition has not deteriorated, but staff have noted their cohesiveness as a unit, which had been noticed on arrival on the new ward, has markedly changed. Whether or not this will affect their behaviour in the community remains to be seen.

Three of the above patients were considered to have been wrongly placed so were moved again. One of these is now under review for a third move, owing to her psychiatric and behavioural deterioration.

To an outsider, one long-stay ward may seem very like another. However, to the patients concerned, a move is a major life event, in this instance made more distressing than

necessary by the absence of preparation. The ward was their home, the staff and other patients their family. These aspects, as well as financial consideration, should be taken into account when a move is planned. Time taken to allow patients to get to know their future wards, by day visits over a period of time, would help to reduce the impact of the change in terms of morbidity and possibly mortality.

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Treatment of pre-senile dementia patients

DEAR SIRS

I was most interested to note the article in which the need for institutional care for those suffering from Huntington's Disease was discussed at some length. (*Bulletin*, June 1987, 11, 187–188).

It may be of some interest to your readers to know that in the five and a half years since I was appointed to Salford Health Authority as a psychogeriatrician I have agreed to accept referrals of all those suffering from presumed pre-senile dementias of all types, originating from a catchment population of approximately 245,000.

As I am sure you will appreciate, this is a somewhat unusual stance for a psychogeriatrician to take and could not be contemplated if I was entirely reliant for facilities upon a District General Hospital base where I would necessarily have to concentrate on those presenting with dementias of later life, leaving the pre-senile group and those with organic brain syndromes of other types, arising before the senium, to the general psychiatrists.

Peculiar circumstances, however, have conspired to allow me to provide a service to this group based in a large mental hospital with a large number of residual long-stay beds, within which provision we have earmarked specific facilities for the long-term care of the pre-senile dement, regardless of diagnostic categorisation.

In addition, in the setting of our limited day care facilities for true elderly severely mentally impaired (ESMI) patients, we provide both day care and community relief admission to a small number of such patients, thereby facilitating their families' almost universal wish to continue to look after such patients up to and often including the time of death within the family home. I am sure you will appreciate these latter provisions thereby circumscribe the facilities that we can provide for the true ESMI patients.

In addition to the available space within the large hospital (before it is closed down) is our proximity to Dr David Neary's pre-senile dementia research unit at the Royal Infirmary, Manchester which provides us with a Regional diagnostic reference centre. Near the Royal