Mental Health Services 2015

Inspection of 24-Hour Community Staffed Residences

COMMUNITY HEALTHCARE ORGANISATION	Area 7
MENTAL HEALTH SERVICE	Dublin South City
RESIDENCE	Ashdale House, Terenure, Dublin 6W
TOTAL NUMBER OF BEDS	10
TOTAL NUMBER OF RESIDENTS	9
TEAM RESPONSIBLE	General Adult
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	17 February 2015
INSPECTED BY	Orla O'Neill, Assistant Inspector of Mental Health Services
ACTING INSPECTOR OF MENTAL HEALTH SERVICES	Dr. Susan Finnerty, MCN009711

Summary

- Ashdale House, a high support residence, was located in Terenure village. The village amenities included a variety of shops, restaurants and cafes, a library, church, synagogue and community health centre.
- The residence was homely if a bit shabby in character. There was a well-developed recovery ethos evident in the daily routines of residents and in the interactions with staff. Each resident had an individual recovery plan which was highly personalised and incorporated physical, psychiatric and psychosocial goals and actions. Residents were fully involved in the process and each resident's views were well recorded and incorporated in their recovery action plan. Residents were provided with a typed copy of their personal plan.
- Each resident had a comprehensive assessment prior to coming to live in the residence. This ensured appropriate placement and focussed care pathway planning. At the time of the inspection visit, nine persons were in residence and a new resident was scheduled to move in shortly.
- The residence was well managed and all records were up to date and designed to support good clinical and social care. The Clinical Nurse Manager (CNM) provided good leadership. Student nurses were facilitated in clinical placements and encouraged to develop projects aimed at enhancing residents' quality of life. There was a full-time housekeeper who was central to providing a homely life-enhancing residence, including freshly cooked meals catered to the preferences of residents.
- The house was not suitable for the accommodation of ten persons. It was not acceptable that all but one resident was required to sleep in a cramped shared room with little provision for privacy and dignity.

Description

Service description

Ashdale House was located on a residential street within the environs of Terenure village. The two-story period red-brick house had a nameplate outside and was easy to locate. Originally a private residence, Ashdale House had been a high support residence for about 17 years. Accommodation was arranged on four levels owing to half-landings and was not wheelchair accessible. Bedrooms consisted of a single room, a 3-bed room and three 2-bed rooms. With the exception of the single room, sleeping accommodation seemed to show little regard for privacy and dignity. Bedrooms were cramped and no screen was provided between the closely spaced beds.

General adult sector teams admitted residents to Ashdale House as part of a dynamic community pathway. On the day of inspection, three sector teams currently had residents admitted to Ashdale House. A recovery ethos was evident throughout activities and practices within the residence.

Profile of residents

On the day of inspection, there were two men and seven women ranging in age from 39 to 65 years living in the residence. One resident was stated to have been living in Ashdale House since it opened. However, most had taken up residency in recent years. A new resident was due to move in shortly and sleeping over for a night was planned as part of the orientation process. All persons resident were voluntary. All residents were required to be fully mobile owing to steep stairs and cramped spaces within some rooms. Each resident had an individual recovery plan which was targeted at promoting optimal functioning and community engagement.

Quality initiatives and improvements in 2014-2015

- Seven residents had been on an annual holiday to Kerdiffstown House in Kildare.
- An audit of the Social Functioning Scale had been completed and records updated for each resident.
- Residents had sown seeds and planted flowers in the garden.
- An audit had been completed of all physical reviews and of all follow-up clinical tests.
- An evacuation folder comprising essential biographical and clinical data for each resident had been compiled. This was to ensure continuity of care in the event that the house had to be evacuated at any stage.

Care standards

Individual care and treatment plan

The standard of care and treatment was good. Each resident had an individual care plan (ICP) entitled a recovery plan. The recovery plan reflected the resident's views which were recorded and the plan was also informed by standardised baseline assessment of psychosocial functioning. Each ICP contained a clear set of goals, interventions and outcomes. The sector multidisciplinary teams (MDTs) reviewed ICPs every quarter and risk assessment was updated then also.

Each resident was provided with a typed copy of their ICP and information was accessible in format. Each resident had an individualised daily routine of activities and participation in community based projects.

Physical Care

Each resident had their own GP. GPs completed six-monthly physical examinations and residents were referred to national health screening programmes as appropriate. The key worker had responsibility for ensuring that a copy of the six-monthly physical examination was recorded in the individual clinical file. The CNM2 audited physical investigations required for residents and any follow up required.

Residents had access to physiotherapy, dietetics, clinical speech and language therapy and occupational therapy through the local health centre. The CNM2 had fostered communication with primary care centre staff and this facilitated resident access and care. Special diets, for example, low sugar or weight reduction diets were catered for within the residence.

Therapeutic services and programmes provided to address the needs of service users

Each resident was assessed by the sector team prior to being admitted to the community residence and a *Need for Care* report based on the *Medical Research Council Needs for Care Assessment* was on file for each resident. This report provided a good account of a resident's needs and functional capacity in everyday living and level of support and healthcare input required. This informed the ICPs developed for each resident. Family input to care planning was evidently valued by the service and nursing notes reflected this. Families were encouraged to become involved in the Eolas mental health awareness and education project.

It was good to see that each resident had their own daily schedule of activities and routines. Some residents participated in the Gateway Mental Health project based at the Rathmines Pembroke community centre in Rathmines. Activities there included arts and crafts, relaxation and meditation, Wellness Action Recovery Plan groups, and a drop-in centre. There was a regular coffee meeting in a commercially run local café. One resident went swimming in the Rathmines public pool. Other residents attended day centre activities at St. James's Hospital. One resident had been attending a day centre in Tallaght. However, the resident was reported to have found the public transport journey time-consuming and tiring and staff therefore assisted the resident in sourcing an alternative community centre programme. There was a local library in Terenure village, cafes and a diversity of shops, all of which were accessed by residents. One of the sector occupational therapists facilitated activities at Ballyroan Community Centre. Residents could access programmes at Eve Community Based Recovery Programmes in the south inner city. The CNM2 and housekeeper were observed actively supporting residents in their recovery in a respectful and person-centred manner. For example: one resident was engaged in a spring clean and pruning of personal belongings and this was affirmed by staff with a reminder of the self-chosen reward of a Chinese take-away meal planned for that evening; one resident was encouraged to go for a walk and requested to pick up some bread for tea from a local bakery. One resident did not attend structured activities outside the residence but was actively involved in daily activities within the house.

How are residents facilitated in being actively involved in their own community, based on individual needs?

Ashfield House was in an ideal location, on a residential street in Terenure village. The residence was well served by public transport and a taxi rank was located a short distance from the house. There were shops, hairdressers, cafes, pubs, a health centre, a library and churches all in the immediate facility. There was a small park nearby, and Bushy Park, with tennis courts and lake was a 20 minute walk or short bus-ride away. The Rathmines community swimming pool was also within easy reach. Residents shopped and socialised locally and had a regular routine of community-based activity. Periodically communal social activities were organised. For example, at Christmas residents had taken a trip into the city centre to visit a Christmas market and to see the lights being turned on and have a meal out. Sunday lunch is occasionally in a local pub.

Facilities

The premises, while being homely was shabby and the design and layout of accommodation as currently constituted was not suitable for a community residence:

- All but one bedroom was shared and cramped, with no provision for privacy;
- There was a lavatory inappropriately situated between the kitchen and the dining room;
- The nursing office doubled up as the clinical room and there was no sink in this room;
- The shower facilities needed upgrading;
- The stairs were steep and narrow;
- The quality of furnishings and décor in the two sitting rooms was dated and shabby; and
- The house, while clean, was in need of redecorating.

As there were plans to build a purpose-built high support residence in Inchicore and to relocate residents there, staff reported that there were no plans to invest money in Ashdale House other than to ensure basic upkeep and safety. The stated time frame for commencement of site work for the new build was summer 2015 and the service advised that the new single room accommodation should be ready for occupancy in the last quarter of 2016.

The residence was clean and tidy. There were laundry facilities and residents looked after their own laundry or could be assisted by the housekeeper if needed. Residents prepared their own breakfasts between the hours of 0800 and 1030h.

There was a small garden and residents had sown seeds and plants. There was a smoking gazebo in the garden.

Meals

Residents prepared their own breakfasts between the hours of 0800 and 1030h. The main meal of the day was lunch which was cooked by the housekeeper and a light tea was provided by nursing staff. The housekeeper took care to cater for residents' preferences. For example, at the time of inspection, a sweet and sour chicken dish with rice or a casserole and potatoes had been cooked to reflect residents' preferences for traditional or spicy foods. Pancakes had been prepared also as it was Shrove Tuesday. Residents were free to make small snacks and drinks up until 2130h.

The shopping was done by the housekeeper and nursing staff and residents were encouraged to participate also. Shopping was valued as a rehabilitation activity.

Staffing levels

STAFF DISCIPLINE	DAY WTE	NIGHT WTE
CNM2	1	0
RPN	1	1
Housekeeper	1	0

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN).

Team input (sessional)

DISCIPLINE	NUMBER	NUMBER OF SESSIONS
Consultant psychiatrist	3	As required.
Non consultant hospital doctor	6	Quarterly and as required
Occupational therapist	1	Weekly
Social worker	1	As required
Clinical psychologist	0	

A non consultant hospital doctor (NCHD) and a community mental health nurse from each of the admitting sector teams visited the residence quarterly. The MDT review of care and ICPs took place at sector offices and the key nurse attended. Outpatient clinics were held at the Jonathan Swift Clinic at St. James's Hospital and at sector offices in Inchicore. Residents usually made their own way to review meetings or outpatient visits but could be accompanied by staff if wished. The recovery care plans inspected showed active resident and family involvement in the process.

Social work input was evident in the clinical files inspected and included family work, facilitating access to allowances and sourcing accommodation. OT input was evident also and residents were supported in all aspects of occupational functioning, including self-care, work and leisure occupations, and these interventions were informed by clear occupational assessment. An OT visited Ashdale House on Wednesdays. Staff reported that there was no clinical psychology input.

Complaints and Incident Recording

There was a leaflet for residents which explained how to make a complaint. There was a complaints log available for inspection and this provided a clear account of complaints made and the actions and outcomes achieved. The nurse manager dealt with complaints in the first instance. The HSE's *Your Service Your Say* policy applied to the residence and information was posted within the residence. A monthly community meeting was held in the residence and proceedings were recorded in a minutes' book. This was inspected and gave an account of open and respectful discussion about aspects of

life in Ashdale House including residents' requests, preferences and views. For example, a request for more hot chocolate, menu preferences, smoking arrangements and housekeeping routines. Discussion with the nurse in charge showed that items decided upon at the community meeting were followed up and reported back at the next community meeting.

There was a record of incidents maintained in Ashdale House and this was inspected. A copy of incident report forms were forwarded to the Assistant Director of Nursing and then subsequently included in the quality and safety governance procedures.

Medication

Medications were prescribed by both the psychiatrist and the GP. Psychotropic medications were prescribed by the treating psychiatrist at the Jonathan Swift Clinic at St. James's Hospital and the residents brought their prescription to the local pharmacy. The pharmacy faxed the prescription to the residents' respective GPs where they were transcribed onto a GMS prescription form which was then sent to the pharmacy. Residents usually collected their own medications; however, medicines could be delivered by the pharmacy also. Residents paid the drug prescription charges to the pharmacy.

Nursing staff administered the medications to residents and there was also a medication administration clinic at the Jonathan Swift Clinic. One resident was on a self-medicating programme, whereby this resident was given a daily supply of medications for self-administration.

The medication storage unit and the medication prescription kardexes were inspected. There were no controlled drugs in use. Doctors used their Medical Council Numbers when prescribing and there was a staff signature bank recorded on each kardex. The discontinuation of medication was recorded with date and signature. Where a resident was spending extended time away from Ashdale House and medication was therefore not administered by nurses, this was generally indicated on the administration record. Medicines were administered in the nursing office which doubled as a clinical room. There was no wash-basin in this room.

The Residence

Ashdale House was owned by the HSE. Residents were individually assessed for charges and there was a record of this available on the day of inspection. Charges were reviewed annually by a Charges Committee or more frequently if a resident's circumstances changed. The standard charge was €115 per week and this included bed and board. There were no additional charges for utilities or for social activities.

Financial arrangements

Residents generally looked after their own financial affairs. Each resident had a bank or post office account. The HSE charge for Ashdale House was paid by direct debit from each resident's personal account to the HSE. Where a resident wished staff to assist in managing daily monies, the resident signed a consent form which outlined the procedure. Each resident could store small amounts of money in the safe and a counter-signed written record was maintained.

Nursing staff were charged with administering the housekeeping monies for the residence. The receipts and account book were available for inspection and appeared in order. HSE administration, based at Cherry Orchard offices, audited all the accounts for Ashdale House. The most recent audit was completed two years ago. The HSE's National Financial Regulation Policy 14 on Financial Management in Community Residences applied and staff were familiar with the content.

Service user interviews

The inspector chatted with several residents. All were happy with their care and treatment, and meals. Staff were regarded as approachable and supportive and the community meeting was considered useful and productive. The main issue for residents was stated to be the shared and cramped bedrooms which provided no privacy or personal space to relax. One resident stated that she used the wardrobe to dress and undress in privacy. The small shared bedrooms were stated to be a discouragement to residents considering coming to Ashdale House. Living in such close proximity inevitably raised issues of personal compatibility at times and addressing this issue required effort and goodwill on the part of residents and staff.

Residents were aware of their ICPs and their personal recovery plan. The independent advocate did not visit but there was information available and residents knew how to make contact if wished.

Conclusion

Ashdale House was ideally located in a residential street on the outskirts of Terenure village. The availability of public transport, amenities and the range of shops and cafes offered residents opportunities for community integration. The standard of assessment and individual recovery plans meant that residents were fully supported in a personalised recovery care pathway. The community based mental health support programmes, such as Gateway in Rathmines and the sessions provided at Ballyroan Community Centre, located residents firmly in the hustle and bustle of the community.

Staff impressed as being energetic and committed to recovery principles and to have empathic, respectful interaction with residents. The records and clinical documentation all attested to a well-managed 24-hour residence.

It was a pity that the house had been allowed to become shabby and had not been well-maintained over the years. The décor, layout and fittings all required upgrading. Basic upkeep and safety were currently being maintained. Staff stated that the proposed new build of residential services in Inchicore meant that monies were unlikely to be invested in Ashdale House. In the meantime, residents were expected to pay for and live in cramped, poorly fitted-out, shared bedrooms which made little concession to privacy and dignity. The toilet and shower facilities required immediate upgrading. Pending the opening of new residential facilities in Inchicore, the HSE should reconfigure the bedroom space in Ashdale to provide single-room accommodation where possible. If a bedroom is to be shared, then adequate space for personal storage and living, and a partition should be installed to ensure respect for privacy and dignity. This would likely require a reduction in bed numbers.

Recommendations and areas for development

1. Single room accommodation should be provided.