Mental Health Services 2012

Inspection of 24-Hour Community Staffed Residences

EXECUTIVE CATCHMENT AREA/INTEGRATED SERVICE AREA	Clare, Limerick, North Tipperary
HSE AREA	HSE West
MENTAL HEALTH SERVICE	Clare Mental Health Service
RESIDENCE	Avonree House
TOTAL NUMBER OF BEDS	10
TOTAL NUMBER OF RESIDENTS	10
NUMBER OF RESPITE BEDS (IF APPLICABLE)	0
TEAM RESPONSIBLE	Community Mental Health Team, West Sector
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	1 November 12

Summary

- This was a residential service for an ageing population of people with dual diagnoses most of whom were discharged from acute care twelve years ago.
- The building on two floors lacked space, had a very steep stairs and was poorly maintained in places. It was due to be closed in 2013 when residents were due to move to alternative accommodation.
- A locum consultant psychiatrist had been appointed in 2012 with responsibility for the North and West Sectors. Prior to that some residents had been reviewed infrequently.
- Multidisciplinary team meetings were not held and multidisciplinary care plans were generally not used. Staff reported that residents were sometimes frustrated and bored.

Description

Service description

This continuing care residence was opened 12 years ago when Our Lady's Hospital in Ennis was closed. Staff reported on the day of inspection that it was regarded as a long stay facility and there had been two admissions since it opened, the most recent in May 2011.

The Inspectorate was subsequently informed that there had been several admissions since the facility opened.

There had been no deaths in the unit in 2012 to the date of inspection.

Accommodation was provided in a two-storey building on the outskirts of Kilrush accessed by steps to the upper floor of the building. This entrance gave access to the day living areas, while most of the bedrooms were on the lower ground floor, accessed by means of a steep stairs.

Profile of residents

There were ten residents, six males and four females and their ages ranged from 51-73 years. All were in care on a long term basis, with one person having been admitted to Our Lady's Hospital in Ennis as a young child. While the service had one respite bed in the past, this was now filled by a permanent resident and the facility for providing respite care had been lost. All residents were voluntary and one resident was a ward of court. Staff reported that as the residents were getting older they required more physical care e.g. with washing and personal care. Some had special dietary requirements. On the day of inspection one resident, awaiting placement elsewhere, was very loud to an extent that staff reported the resident was disturbing others in the house.

Quality initiatives and improvements in 2011/2012

A locum consultant psychiatrist had been appointed during 2012.

Care standards

Individual care and treatment plan

Of the three clinical files examined, one individual had a multidisciplinary care plan. Multidisciplinary team meetings were not held. Staff reported that residents had access to psychology and social work services from the community mental health teams, although these were used infrequently.

There was evidence in the clinical files of the involvement of chiropractors in the care of residents. Staff reported this service was accessed and paid for independently by residents and not covered by their medical cards.

Some of the language used in nursing care plans was antiquated and seemed not to be in keeping with a recovery ethos e.g. staff were asked to identify patient 'deficits'. Residents were identified as 'patients' although they were in community services.

Residents were seen infrequently by psychiatric staff e.g. in the case of one clinical file inspected, there was no evidence that one resident had been reviewed by a psychiatrist between 2009 and 2012. The resident had been reviewed in July 2012 by the locum consultant psychiatrist. Psychiatrists did not always print their names or use their medical council numbers (MCNs) in accordance with best practice. In one instance, the MCN number only was used, there was no signature.

Formal risk assessments were not used, although staff reported concern for their own and patient safety and well being.

A procedure was in place in the case of incidents occurring. The Inspectorate was advised that the clinical risk advisor based in Limerick was contactable in the event of advice being required.

The clinical notes were sometimes written on 'outpatient' notes and sometimes **on 'in-patient'** notes. Some pages in the clinical files were loose and in danger of being mislaid. Clinical notes were sequential but it was difficult to identify the disciplines of staff making entries.

Staff reported that they had received mandatory training in the past, but no training in the last two years. They had not received training in working with people who had an intellectual disability.

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

General health care was provided by the residents' general practitioners (GPs), who saw residents either in their surgeries or in the residence if requested. Staff reported that the GPs did six-monthly physical assessments. One GP was engaged for nine of the ten residents and there was evidence in the clinical files of GP involvement with residents although these entries were not always signed.

One resident attended a day centre and another attended a workshop. Others did not attend an occupational facility during the day. Staff reported that boredom was a problem for the residents. They did not have access to a kitchen for tea-making facilities.

Music and art therapy was provided on a weekly basis and residents paid a contribution of three euro for this.

A treadmill was available. One resident had purchased an exercise bike for their own use.

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

The residence was located close to the centre of Kilrush. Staff reported that most residents were not capable of going into town alone.

Staff reported they were accompanied at least every second day to the town for coffee or on trips further afield in the Clare area. On the day of inspection one member of staff had accompanied residents to Mass in the local church.

There were no community groups involved in the provision of services to the residence. A representative of the Irish Advocacy Network did not visit.

Facilities

Accommodation was provided in two double bedrooms and six single rooms. All had wash-hand basins, wardrobes and lockers. All were provided with curtains and the double rooms had privacy curtains. The wardrobes could be locked by the residents. While some rooms were bright and sunny, others were dark and musty.

There was one bathroom and two shower rooms in the building but only one was used. Staff were unaware of the reason for this. The available shower was accessed via one resident's bedroom. This room felt cold on the day of inspection and had a rotting skirting board. Staff reported that windows were single glazed and draughty. The shower room door was not lockable. A separate toilet was malodorous and there was evidence of rusting pipes.

Staff reported that they were unaware of any redecoration that had taken place in the facility in recent years. Plans were at an advanced stage to move to an alternative facility in early 2013, so only essential maintenance was being carried out on the premises as a result.

The staircase was a cause for concern as it was very steep. Staff reported they were afraid residents would fall, or that someone could be pushed and seriously injure themselves.

There were two sitting areas. One of these was very small and had originally been intended as a visitors' room. The other while larger, was dark and institutional in appearance. Staff reported the area was too small and cramped to meet the needs of residents who were sometimes frustrated as a result.

The kitchen and dining area was bright and staff reported that prepared meals were brought from the central catering in the Orchard Lodge complex. There was no facility for a kitchen for the use of residents. A utility room was available for laundry. Staff reported that most were unable to do their own laundry, so this was done for them by housekeeping staff. Residents' clothes were labelled and identifiable.

Staff reported that fire inspections were conducted on a two-monthly basis and staff checks were done daily.

Staffing levels

STAFF DISCIPLINE	DAY WTE	NIGHT WTE
Nursing	2 RPNs	2 RPNs
Housekeeping	1	0

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Non Consultant Hospital Doctor (NCHD).

Team input

DISCIPLINE	NUMBER	NUMBER OF SESSIONS
Consultant psychiatrist	1 for 9 residents (CMHT 1 for 1 resident (Rehabilitation and Recovery team)	Fortnightly or as needed
NCHD	0	0
Occupational therapist	0.5	Accessed infrequently from day hospital
Social worker	0.5	Accessed infrequently from CMHT
Clinical psychologist	1	Accessed infrequently from CMHT
Other – Art teacher Music teacher	1 1	1 session per week 1 session per week

Medication

Only one resident was prescribed a regular benzodiazepine. Eight residents were prescribed an antipsychotic medication and five (45%) were taking more than one. It was good to see that only one resident was on high dose antipsychotic medications. Prescriptions were legible but not all doctors used their Medical Council Number (MCN) when prescribing. Some prescriptions were out of date, having been prescribed in November and December 2011. In two instances, a 'once only' prescription had been administered to residents but was not signed by the nurse administering the medication.

MEDICATION

NUMBER OF PRESCRIPTIONS:	11	%
Number on regular benzodiazepines	1	9%
Number on more than one benzodiazepine	0	0
Number on PRN benzodiazepines	6	55%
Number on benzodiazepine hypnotic	0	0
Number on non benzodiazepine hypnotic	3	27%
Number on PRN hypnotic	1	9%
Number on antipsychotic medication	8	73%
Number on high dose antipsychotic medication	1	9%
Number on more than one antipsychotic medication	5	45%
Number on PRN antipsychotic medication	3	27%
Number on Depot medication	2	18%
Number on antidepressant medication	2	18%
Number on more than one antidepressant	0	0
Number on antiepileptic medication	3	27%
Number on lithium	0	0

Tenancy rights

Residents paid €67 per week for rent and food.

Staff reported that residents had been informed that they had a right to remain in the residence for life and an agreement had been signed to this effect, but no record was available on the day of inspection. The service did not forward a copy of the agreements as requested to the Inspectorate.

Staff reported that periodic community meetings took place with residents.

Staff reported that they did not receive complaints but there was a procedure for dealing with them if necessary. The complaints procedure was not highlighted.

Financial arrangements

Staff reported that residents' allowances were managed by staff who gave money to them as needed. They reported that most residents would not be able to manage their own finances and were happy for staff to do it for them. This was not recorded in the clinical files.

Staff reported residents had agreed to this as part of their multidisciplinary care plans, prior to their discharge from Our Lady's Hospital twelve years previously. There was no record of this available on the day of inspection.

Copies of residents' consents to the financial arrangements were not forwarded to the Inspectorate as requested.

Service user interviews

A number of residents were greeted by the Inspectorate during the course of the inspection and all said they were satisfied with their care.

Conclusion

This residential service for people with dual diagnoses was developed 12 years ago. Residents were getting older and the building was unsuitable for an ageing population. There was insufficient living space, a steep stairs which staff felt was dangerous and an insufficient level of therapeutic activities. On the day of inspection, parts of the building were cold and there was evidence of dampness and rust in some areas. There was one shower for ten adults. Staff reported that these issues would be addressed when the residents moved to alternative accommodation nearby in 2013.

The two nursing staff had no immediate supervisor as the CNM2 who was on leave, had not been replaced. In emergency, staff could be contacted in the nearby day centre or the ADON could be contacted in Ennis. They reported they had received no training in the last two years and had never received training by the HSE in working with people with an intellectual disability.

The Inspectorate was concerned at the infrequent reviews undertaken by psychiatric staff. This had not been done for some years in the case of one file reviewed. In some instances, clinical notes were not always signed appropriately i.e. in one instance the medical council number only was used and there was no signature while in other instances signatures were not always accompanied by a printed version. A locum consultant psychiatrist had begun to address this with evidence of some reviews having been undertaken in July 2012.

There was evidence of extensive GP involvement with residents, but GP entries in the clinical files were not always signed.

Policies available to the Inspectorate were out of date. Some were more applicable to the in-patient, than to community services. The Inspectorate was subsequently informed that up-to-date policies were available online, but staff were not aware of this on the day of inspection.

The language used was inappropriate for a Recovery oriented mental health service e.g. staff were asked to identify the ‘patient’s diagnosis or deficit’ when completing nursing care plans.

Clinical notes were completed inconsistently on either ‘in-patient’ or ‘outpatient’ headed paper. Pages were loose in many instances and in danger of falling out of the files.

Recommendations and areas for development

1. Clinical reviews should be completed regularly by psychiatric personnel.

2. The move to the new building should proceed as soon as possible.

3. Multidisciplinary team meetings should be held regularly.

4. Consideration should be given to the introduction of multidisciplinary care plans.

5. All clinical notes should be appropriately signed by the relevant personnel.

6. Consideration should be given to the introduction of differently coloured tags for the identification of different professions.

7. Staff should be given the opportunity to avail of training on a regular basis. In particular, they should receive training in working within a Recovery ethos and in working with people with an intellectual disability.

8. The templates for all clinical notes should be reviewed so that the language used is in keeping with a modern approach to care.

9. As this is a continuing care facility, the impact of new referrals on the existing residents should be taken into consideration, prior to admission.

10. Policies should be updated to reflect the needs of the residential community service.

11. Management of residents' finances should only be done with their consent. This should be documented in the clinical files.

12. Residents' money should be managed in accordance with HSE National Financial Regulations.

13. All prescriptions should be in date and doctors should use MCNs when writing prescriptions.

14. Staff must sign when administering a medication to a resident.