Mental Health Services 2015

Inspection of 24-Hour Community Staffed Residences

COMMUNITY HEALTHCARE ORGANISATION	Area 1
MENTAL HEALTH SERVICE	Sligo
RESIDENCE	Benbulben Lodge
TOTAL NUMBER OF BEDS	7
TOTAL NUMBER OF RESIDENTS	7
TEAM RESPONSIBLE	General Adult
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	04 February 2015
INSPECTED BY	Seán Logue, Assistant Inspector of Mental Health Services
ACTING INSPECTOR OF MENTAL HEALTH SERVICES	Dr. Susan Finnerty, MCN009711

Summary

- The assistant inspector had difficulty gaining access to the community residence because the residence was gated by a barred metal electronic gate which was shut. The assistant inspector could find no other means of access to the residence. No doorbell could be located by the assistant inspector around the area of this gate, in particular, around the area where the coded keypad to the gate was located.
- Twin bedrooms were small and afforded no privacy and dignity to the residents using them.
- There was no complaints procedure displayed in the residence.
- The prescription sheets used by the service for both prescribing and administrating medicines were outdated in that they did not meet current practice standards and needed to be reviewed.
- Although staff handled residents' monies, a financial policy in relation to this could not be produced by staff of the residence upon request by the inspector.
- The individual care plans (ICPs) were multidisciplinary in content.
- There was a good choice of main meal each day.

Description

Service description

Benbulben Lodge was a two-storey house, formerly a private residence, which was situated in a rural location on the N15 road between Sligo and Donegal, approximately 14 kilometres north of Sligo town. It was situated on large grounds at the foot of Benbulben. The residents had been transferred from the special care unit (SCU) in the acute psychiatric in-patient unit in Ballytivnan in December 2013.

The assistant inspector had difficulty gaining access to the community residence. The residence was gated by a barred metal electronic gate which was shut. The assistant inspector could find no other means of access. No bell or intercom system could be located by the assistant inspector around the area of the gate, in particular, where the coded keypad to the gate was located. The assistant inspector phoned the residence twice but the phone rang out. The assistant inspector was eventually able to attract the attention a staff nurse.

The Clinical Nurse Manager (CNM) of the residence was not on duty on the day of the inspection and the assistant inspector questioned the staff nurse in charge about the absence of the bell at the gate and that the residence appeared to be inaccessible to outsiders and the access and egress of residents. The staff nurse in charge indicated to the inspector that he believed there was a bell as he had heard it sounding inside the residence on a number of occasions. The residents, it was reported by the CNM2, would not have the mental capacity to leave the premises unaccompanied. The gate, it was noted by the inspector, was not difficult to scale, as it was a barred gate of approximately 1.5 m in height. For safety reasons, a pedestrian gate might be justified and this needs to be addressed by the service. At the conclusion of the inspection, the inspector requested that the staff nurse in charge show him the whereabouts of the bell around the area of the gate but the staff nurse was unable to locate it.

The inspector also informed the staff nurse in charge that he had been parked outside the gate for approximately ten minutes and had phoned the telephone number of the residence twice but it had rung out. The staff nurse in charge indicated that he had not heard the phone ring. The phone number the inspector had in his documentation in relation to the residence was checked and was established to be the correct telephone number.

The philosophy/ethos of the residence was requested by the inspector but this could not be located by staff of the residence.

Profile of residents

There were seven residents in the community residence: six males and one female. All residents were voluntary and there were no wards of court. The age profile of residents was from 50s to mid-60s. All residents were fully mobile. All residents had been transferred from the SCU in Ballytivnan in December 2013.

Quality initiatives and improvements in 2014-2015

- A seven-seat car had been acquired by the residence.
- Approximately 14 hens were acquired by the service to occupy an existing hen house and laying house and these were tended to by a resident.

Care standards

Individual care and treatment plan

The individual care plans (ICPs) were multidisciplinary in content and entitled “MDT Integrated Recovery Care Plan”. They included the strengths of the resident and any education requirement or need. The resident signed these care plans. There was evidence of regular review. The multidisciplinary team (MDT) had initially met once a week in the residence for a year following the transfer of the residents from the SCU and now met one Friday a month. It was reported that the resident attended these meetings. A member of nursing staff from the residence was included in this MDT meeting. Risk assessment was used and there was a regular evaluation of risk in each clinical file which fed into a risk management plan.

The quality of the MDT care plans for each resident appeared good at first glance. The ICPs were well recorded but, upon inspection, did not convey practical realisation of any recovery- oriented practice or the service’s responsibility in relation to the promotion of optimal functioning of each resident. If a recovery care plan, such as was inspected by the inspector, was in full operation, there should be documentation within the clinical file of base-line assessments of functional independent living skills having been completed and the steps identified to promote optimal functioning of each resident.

It was reported that none of the nursing staff on duty on the day of inspection was a regular member of staff.

The residents were not under a specialist rehabilitation team but a sector team.

Physical Care

The six-monthly physical health reviews were undertaken by the non-consultant hospital doctor (NCHD) and there was documentary evidence of regular physical examinations of all residents. All residents had their own general practitioner (GP). Residents had access to all available national health screening programmes. Access to a dietician, physiotherapy and speech and laguage therapy was available, where needed.

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

There was a white board inside the residence which displayed the therapeutic activities being undertaken in the residence. Included in this were word wheel, outings, home visiting, walks, shopping and relaxation.

Kitchen facilities were not accessible to residents because staff reported that all residents were incapable of attending to their own needs in this regard.

There was a small kitchen located in one of the stand-alone buildings to the rear of the premises. The occupational therapist attended weekly and assisted at most two residents, with baking breads and cakes.

No resident attended a day hospital, day centre or training/education facility.

How are residents facilitated in being actively involved in their own community?

One resident attended many local GAA matches and a second resident also attended some of these.

The residence was located in a rural setting on the foot of Benbulben, immediately adjacent to the N15, which was a busy road. There were no footpaths to the side of this road for many kilometres on both sides of the residence. There was no pedestrian gate to offer entry and egress to the residents. The only gate was a large metal-barred, electric gate which was always shut. A number of residents went for coffee or to the beach but this required being accompanied by staff in the service's seven-seat vehicle in respect of these activities.

The grounds within the premises were large, more like a farmyard in appearance and upkeep than a garden, although there was a small garden space immediately to one side of the residence.

Facilities

On the day of inspection there were three twin-rooms, comprising two that were occupied by two residents each and one with one bed that was being used as a single room by one resident. There were two single rooms. The twin bedrooms were small and afforded no privacy and dignity to the residents using them. Maintenance of the residence was reported to be good and maintenance staff were based in the acute hospital in Ballytivnan.

A shower room, the door of which immediately opened onto the landing directly at the top of the stairs, could not be used and for safety reasons was locked on a permanent basis.

There was one cook and one multi-task attendant who undertook cleaning. Residents were encouraged to keep their personal belongings and immediate space around their beds in a tidy manner. Residents had access to a washing machine for laundry.

Meals

Residents did not cook their own meals, nor did they have access to the main kitchen in the residence to make tea or coffee, which was accessed by staff through a keypad lock system. Meals and snacks were served regularly. A menu was displayed and there was a good choice of main meal each day. Porridge was prepared each morning. Residents, it was reported by both the cook and nursing staff on the day of inspection, had no input into the menu choice. A number of residents accompanied staff on the weekly shopping trip.

Staffing levels

STAFF DISCIPLINE	DAY WTE	NIGHT WTE
RPN (including CNM)	4	2
Cook	1	0
MTA	1	0

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Multi-task Attendanct (MTA)

Team input

DISCIPLINE	NUMBER	NUMBER OF SESSIONS
Consultant psychiatrist	1	Once monthly but also as required
NCHD	1	Once weekly but also as required
Occupational therapist	1	Friday pm
Social worker	1	Once monthly
Clinical psychologist	0	

Non-consultant Hospital Doctor (NCHD)

Complaints

There was no complaints procedure highlighted. There was no log of complaints. It was reported that no complaints had been received by the service. No information was provided to residents or visitors about how to make a complaint.

The complaints officer was not highlighted. Community meetings were not held. A log of incidents was available to the inspector and was satisfactory.

Medication

The GP prescribed medication on a General Medical Scheme (GMS) Prescription Card which was brought to the GP practice for completion and the NCHD) then transcribed this prescription onto a separate Mental Health Service Community Prescription sheet. The prescription sheets used by the service for both prescribing and administrating medicines were outdated in that they did not meet current practice standards.

There was no information provided on medication. No resident was managing their own medication. Medication was supplied by the local pharmacy.

The Residence

The Health Service Executive (HSE) owned the residence. Each resident paid €100 rent and €50 towards housekeeping (food and utilities) each week. This charge was across the board for all residents and not individually determined. This was contrary to the HSE policy on in-patient charges as they apply at page 8 of that document in relation to community residences. Community meetings did not take place.

Financial arrangements

The inspector asked for the service's policy on its financial arrangements but this was not located. Staff handled residents' monies in relation to the rent and housekeeping. One resident had a bank account and also managed theirown finances. The remaining residents had bank and post office accounts but staff managed their monies. It was reported that these residents required supervision to manage their respective monies. Each resident, in this regard, had an account book and this was managed by nursing staff. All transactions were receipted and signed by two members of staff. These account records were audited by HSE administrative staff on an annual basis.

There was no group kitty or social fund and residents used their money as they wished.

Service user interviews

No resident requested to speak to the assistant inspector. Residents were greeted by the assistant inspector.

Conclusion

Benbulben Lodge was a two-storey house, formerly a private residence, which was situated in a rural location on the N15 road between Sligo and Donegal, approximately 14 kilometres north of Sligo town. The residence was somewhat institutional in operation. This was evident from the lack of personalised or homely features in the sitting rooms, dining room and bedrooms. Residents did not cook their own meals, nor did they have access to the main kitchen in the residence to make tea or coffee. The kitchen could only be accessed by staff through a keypad lock system. There were no community meetings for residents to input into the running of the residence, no input by residents into the menu and no complaints procedure highlighted.

There was evidence of regular MDT review. The quality of the MDT care plans for each resident appeared good at first glance but they did not convey practical realisation of any recovery oriented practice or the service's responsibility in relation to the promotion of optimal functioning of each resident.

Entry to, and egress from, the residence posed difficulty to the inspector and presumably, by definition, to the public in general.

Many of the residents, it was reported, were reluctant to engage in therapeutic activities apart from one or two. In those instances, for short periods only.

Recommendations and areas for development

1. *Access to the community residence and egress should be uninhibited and requires immediate review by the service, bearing in mind the health and safety of residents.*
2. *For safety reasons, a pedestrian gate might be justified in addition to the main gate and this needs to be addressed by the service, bearing in mind the health and safety of residents.*
3. *All bedrooms should be single occupancy only.*
4. *The prescription sheets for prescribing and administering medicines to residents should be updated.*
5. *The complaints procedure for the community residence should be displayed and done so in a prominent area of the residence.*
6. *A system should be put in place for residents to pay their rent other than the need for staff of the residence to handle it.*
7. *A visible gate bell should be installed to alert staff to visitors.*
8. *The service should employ the HSE in-patient charges policy as they apply to community residence*
9. *The service should have a policy on the handling of residents' monies by staff.*