Mental Health Services 2015

Inspection of 24-Hour Community Staffed Residences

COMMUNITY HEALTHCARE ORGANISATION	Area 8
MENTAL HEALTH SERVICE	Laois/Offaly
RESIDENCE	Birchwood House, Tullamore
TOTAL NUMBER OF BEDS	14
TOTAL NUMBER OF RESIDENTS	11
TEAM RESPONSIBLE	Rehabilitation
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	4 March 2015
INSPECTED BY	Dr. Enda Dooley, MCN 004155, Assistant Inspector of Mental Health
ACTING INSPECTOR OF MENTAL HEALTH SERVICES	Dr. Susan Finnerty, MCN009711

Summary

- Birchwood House was a 14-bed 24-hour nurse staffed residence located in central Tullamore. The residence was somewhat dated and should seek to provide single room accommodation for all residents.
- Renewed focus should be brought on maximising the independence and autonomy of residents.
- While residents all had an individual care plan (ICP) it was apparent that review of this did not involve the entire multidisciplinary team (MDT).
- A complaints log and a record of incidents occurring and responses provided should be maintained within the residence.

Description

Service description

Birchwood House was a single storey residence, which formed part of a larger care complex close to the centre of Tullamore. It opened in 1991. It functioned under the direction of the Rehabilitation team. It contained seven twin bedrooms with separate toilet and bathroom facilities.

Staff indicated that the philosophy and focus of care was to promote independent living skills and facilitate a move to lower support accommodation. The residence catered for a population with a long history of severe and enduring mental illness. Staff indicated that this chronicity of illness and the gradual aging of the resident population presented increasing problems in achieving progression to lower support. Staff of the residence were also responsible for a number of medium and low support residences in the locality.

Profile of residents

The residence had a capacity for 14 residents. On the day of inspection there were 11 residents, four males and seven females, aged from 50 to 69 years. Residents had spent between six months and 20 years in the house. All residents were voluntary status. Two residents had significant sight impairment and required assistance with daily activities. All residents were mobile.

Quality initiatives and improvements in 2014-2015

- An activation room had been developed within the residence. A Health Care Assistant (HCA) has been specifically trained to facilitate activities including art and pottery.
- The residence now had its own transport to facilitate outings, etc.

Care standards

Individual care and treatment plan

The focus of care was on maximising independence. All residents had a key worker. The clinical files were reviewed and all residents had an individual care plan (ICP). These care plans were reviewed on a monthly basis by the keyworker and at approximately six-monthly intervals by the responsible consultant psychiatrist. The consultant visited the residence on a weekly basis. The residents were involved in the review of their care plan and all had either received a copy of their most recent review or signed a refusal. From the documentation available and discussion with staff, it appeared that ICP review involved medical and nursing personnel but not members of the extended MDT.

Staff indicated that there was no formal risk assessment process applied on admission and that there was no formal review process in place for pre-existing risk reviews undertaken.

Staff presented as supportive and engaged with residents. Because of the gradual increasing dependency of residents it was necessary for staff to accompany residents to outside events.

All residents were up and about during the course of the inspection. One resident was being managed in night-clothes and the clinical reasons for this strategy were documented and reviewed in the individual's clinical file. The application of an apparently restrictive practice in a voluntary environment was a source of concern. A report on this matter was requested from the responsible consultant and this indicated that in July 2013 the resident had signed a consent for the withdrawal of his mobile phone and shoes in certain circumstances. There was no indication that this consent had been reviewed or renewed at any time in the interim. In light of concerns regarding the capacity of this resident consent should be reviewed on a regular basis and any consent should have the documented support of an appropriate advocate. Any consent should specifically cover the interventions proposed and where these pose a significant impairment of personal liberty the interventions and associated consents should be reviewed at frequent intervals.

Physical Care

All residents had their own GP. The key worker was responsible for ensuring that the resident attended for regular six-monthly physical reviews. Generally, residents would attend the GP accompanied by the key worker and any issues arising or follow-up required would be reported back by accompanying staff.

Residents were encouraged to partake in screening programmes and prophylactic vaccination (e.g. annual flu vaccine). Access to specialist services such as physiotherapy and dietician was through primary care.

Families were encouraged, subject to the resident's consent, to be involved in on-going physical healthcare and this included accompanying the resident to out-patient appointments.

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

A variable programme (depending on staff resources) of therapies, including art, pottery, bingo, games, and newspaper reading was organised within the house. Two residents attended the day hospital on Bury Quay where a variety of therapies were organised. Staff commented that one resident had been in paid employment with the Health Service Executive (HSE) until recently.

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 Tullamore and was convenient for access to the town amenities. Residents had ready access to shops and other social amenities. A number of residents went out for coffee regularly and cinema trips were organised when there was sufficient demand. Families were supportive and a number of residents went out on leave. Residents could meet with family members in the residence or, alternatively, elsewhere in the town.

Staff indicated that in the past an annual holiday for residents had been organised but that this had not occurred last year due to lack of interest on the part of the resident group.

Facilities

The residence was a single storey building located within the grounds of a larger care complex which incorporated a primary care centre. All bedrooms (male and female) were twin rooms which were minimally furnished. The male and female accommodation was on separate sides of the house divided by the central living area. There was no provision for personal privacy in any of the bedrooms. None of the bedrooms had en suite facilities and residents did not have the facility to lock their rooms. Bedrooms were of various shapes providing residents with variable amounts of personal space.

Toilet and shower facilities were cramped with some missing tiles and a broken shower fitting in one bathroom. The overall décor of the residence was drab and re-decoration was needed in a number of areas.

The main sitting room was dated in décor and would benefit from redecoration and refurnishing. Residents had access to TV (including satellite), DVDs, books and radio. There was a smoking shed in one area of the garden and this was very untidy, as it was covered in ash and cigarette butts which were swept onto a nearby border area at intervals. This posed a potential fire hazard.

The clinical room was very small and was used for the storage of medicines.

The dining room area was adequately furnished for the resident population but furnishing was uninviting and functional. The room also had a TV (which could be available if there was demand). The kitchen had been recently renovated and was available to residents. There was a laundry room where staff organised washing of patient clothes on an individual basis.

Adjacent to the kitchen, a very pleasant garden had been developed and this provided an inviting amenity, particularly in summer. The garden development contrasted with the state of external maintenance on the rear of the residence which showed evidence of cracking plaster and peeling paint.

There was a public phone in the house but most residents either used their personal mobile phone or were facilitated by staff in using a hands free landline.

Meals

All meals were provided from a central kitchen located elsewhere within the care complex. Residents had independent access to the kitchen in the residence should they wish to prepare food or drinks themselves. Staff informed the inspector that a choice of meal was provided every day but no menu cycle was readily available. If a resident had particular needs or preference this could be catered for.

Staffing levels (full time in residence)

STAFF DISCIPLINE	DAY WTE	NIGHT WTE
CNM 2	1	0
RPN	1	1
HCA	1	0
MTA	1	1

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA), Multi-Task Assistant (MTA)

Team input (sessional)

DISCIPLINE	NUMBER	NUMBER OF SESSIONS
Consultant psychiatrist	1	One weekly
NCHD	0	0
Occupational therapist	0	0
Social worker	0	0
Clinical psychologist	0	0

Non-Consultant Hospital Doctor (NCHD)

Nursing and care staff were responsible for a number of other supported residences in the locality and this diminished the overall staff input to the residence.

The responsible consultant psychiatrist visited the residence on a weekly basis and undertook clinical review of scheduled ICP review with the nursing staff. Staff indicated that input from other members of the MDT was infrequent and they were not directly involved in review of the ICP.

Complaints

While the residence had a notice board in a communal area, and this contained information regarding a variety of local community and healthcare supports, there was no information available regarding a complaints mechanism. Staff indicated that the designated complaints officer was the administrator of St. Fintan's Hospital, Portlaoise. There was no complaints log maintained in the residence. Staff indicated that there were currently no regular community meetings held in the house as these had been unpopular with residents. It was reported that residents preferred to raise issues with their key worker.

There was no incident book retained in the house. Staff reported that any incident arising were reported on a pro forma sheet to management but no copy was kept and it was inconsistent for receipt of confirmation that the incident had been addressed satisfactorily.

There was no input to the residence from an independent advocate.

Medication

Medication was prescribed by the responsible consultant or by the GP. Current medication was updated on a kardex system by the consultant. The kardex system in use had specific provision for inclusion of the prescribers Medical Council Number and so this legal requirement was observed systematically. Medication was supplied by a local pharmacy in individual blister packs and administered by nursing staff. No resident was self-medicating.

The Residence

The residence was owned by the HSE. All residents paid a weekly charge of €60 and this covered bed and board. There was no individual assessment of charges payable. Residents were personally responsible for prescription charges. A number of residents paid their weekly charge by means of regular debit to the HSE. In other cases, charges were paid by cash and a receipt issued.

Financial arrangements

All residents had a personal post office or bank account. Residents with limited capacity to manage their affairs were assisted by staff. A supply of resident's cash was held in the house by staff. An individual account of this cash was held and reconciled daily. Any withdrawals of cash by a resident were signed by both staff and the resident.

There was no social fund or common 'kitty' held within the house.

Service user interviews

A number of residents were greeted during the course of the inspection. None expressed any concern or complaint regarding the residence. One resident requested to meet with the inspector individually. The issue raised was long-standing and well known to staff and did not relate to the operation of the residence or his care there.

Conclusion

Birchwood House was a nurse-staffed residence accommodating up to 14 residents with a history of severe and enduring mental illness. On the day of inspection there were 11 residents. The residence had functioned as a community residence for over 20 years and the accommodation was dated and in need of renovation.

Staff were supportive and engaged with residents. There had been efforts, with the development of an activities room, to expand the range of therapies available within the House.

While the focus was on maintaining and maximising independent functioning and autonomy, it was apparent that, over time, residents were becoming less motivated and more dependent. ICPs were regularly reviewed and it was clear that this involved the resident. Development and review of ICPs should involve the whole MDT.

Contrary to stated HSE policy, there was no indication that the charges payable had been assessed on an individual basis.

Recommendations and areas for development

1. *Priority should be focussed on providing residents with single accommodation consistent with the recommendations of 'A Vision for Change'. Steps should be taken to provide adequate safeguards for the privacy and dignity of residents.*

2. *There should be renewed therapeutic focus on promoting and maximising the independence and autonomy of residents. Residents should be encouraged and facilitated in cooking their own meals, undertaking their own laundry among other things.*

3. *The development and review of the resident's individual care plan should involve the entire multi-disciplinary team.*

4. *There should be a complaints log maintained and clear information available to residents and visitors on the procedure for making a complaint.*

5. *A record of incidents occurring should be kept in the residence and this should include steps taken to resolve any issues arising.*

6. *To minimise the possibility that a regular physical review might be overlooked, staff should maintain a schedule list documenting when such assessment last occurred and when it is next due.*

7. *Procedures should be put in place to ensure that the weekly charges payable by any resident have been individually assessed in line with the HSE policy.*

8. *Where any curtailment of individual liberty is deemed to be the least restrictive clinical pathway for a resident considered 'voluntary' the circumstances and consents covering any such restriction should be comprehensively documented and frequently reviewed.*