Mental Health Services 2015

Inspection of 24-Hour Community Staffed Residences

COMMUNITY HEALTHCARE ORGANISATION	Area 2
MENTAL HEALTH SERVICE	East Galway
RESIDENCE	Brook House, Mountbellew, Co. Galway.
TOTAL NUMBER OF BEDS	7
TOTAL NUMBER OF RESIDENTS	7
TEAM RESPONSIBLE	Sector
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	3 February 2015
INSPECTED BY	Dr. Enda Dooley, MCN004155, Assistant Inspector of Mental Health Services
ACTING INSPECTOR OF MENTAL HEALTH SERVICES	Dr. Susan Finnerty, MCN009711

Summary

- Brook House was a seven-bed residence in the town of Mountbellew. It catered for a mix of long-term residents and also had provision for respite care and assessment.
- Staff were supportive and had a good relationship with residents.
- Residents had access to a range of social and therapeutic interventions.
- While clinical notes were updated regularly by nursing staff there was no evidence of a structured individual care plan (ICP) for residents.
- Residents did not have the means to secure their personal possessions.
- The responsible multi-disciplinary team (MDT) was incomplete as it was currently short an occupational therapist (OT) position. This had a detrimental effect on the assessment of, and care planning for, residents.

Description

Service description

Brook House was an extended residence (bungalow and two-storey) located within the town of Mountbellew. It was opened in 1996 and one resident has been in the house since that time. The facility had a rehabilitation ethos though staff indicated that this was somewhat frustrated by the lack of suitable facilities for independent living in the locality. There was one respite bed which facilitated assessment of individuals who were encountering difficulty in managing in lower support accommodation. The house was owned by a local voluntary mental health association and was maintained by the Health Service Executive (HSE).

Profile of residents

The house consisted of seven single bedrooms on two floors. One place was deemed respite and had been occupied since October 2014 by a resident for whom a suitable long-term placement was being sought. On the day of inspection, there were three female and four male residents aged from 31 to 65 years. With the exception of one resident all were over 45 years. Residents had been in the house between one and 19 years. All residents were mobile and none required specific mobility or other assistance.

Quality initiatives and improvements in 2014-2015

Staff indicated that there were proposals to renovate the bathrooms in the residence but that this had not been finalised yet.

Care standards

Individual care and treatment plan

Care plans were maintained in consultation with the residents. Residents had a designated keyworker from amongst the nursing staff of the facility. There was no formal, structured ICP maintained within the clinical records. MDT reviews, usually involving medical and nursing staff, were held in the local day centre. The frequency of such reviews depended on clinical need. Reviews were attended by the keyworker but not necessarily by the resident. A new sector consultant had recently taken up post and clinical organisation was presently in a state of flux according to staff. This included the possibility that responsibility might be transferred from the sector team to a dedicated rehabilitation team.

In recent years, a number of former residents had moved to nursing home care due to advancing age. None had moved to independent living as there were in accessing suitable accommodation in the area.

Staff indicated that a risk assessment was undertaken at time of admission and thereafter as required. There was no indication in the clinical files that this was a regular or structured process.

Staff presented as positive and proactive with residents. They assisted residents with daily activities and other social supports.

Physical Care

All residents had their own GP. Staff reported that residents attended their GP on a relatively frequent basis, usually in relation to specific issues. There was no structure for recording that regular six-monthly physical reviews had been undertaken or were scheduled into the future. Residents availed of recommended screening programmes (Breast Check). Access to specialist services was through primary care. Staff accompanied residents to out-patient or other hospital appointments.

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

Residents had access to the kitchen under supervision. Staff prepared morning and evening meals. Residents attended a local day centre or, alternatively, a training centre in Ballinasloe and had lunch provided in these locations. At weekends, residents dined in a restaurant in the town. No meals were cooked by residents in the house.

Some residents attended Creagh Training Centre in Ballinasloe on a number of days each week. They were collected in the morning by bus and returned in the evening. Alternatively, residents attended a local day centre which was within walking distance and where a number of therapies and programmes were provided.

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

Residents had ready access to the local community. A number of residents attended mass locally on a regular basis and also engaged in other community activities such as going to the pub or local sports events. While visits could be accommodated within the house, residents would generally go out with visitors to the local demesne or to the town itself.

Facilities

Brook House was a converted and extended domestic residence. Each of the residents had their own room which was furnished with wardrobe and bedside lockers. In some cases, available storage space was inadequate for the resident's needs. Residents did not hold a key to their room and did not have access to any private secure storage.

The overall condition of the house was good and routine painting was undertaken on a regular basis. The surrounding gardens were well maintained and one of the residents with an interest in gardening was actively involved in this activity. Bathrooms within the house required renovation and it was notable that a number of ligature anchor points existed within the house. Bathrooms were lockable and, if necessary, the locks could be over-ridden by staff. There was adequate dining and sitting space within the house. Furnishings were comfortable and there were a number of TV's, radios, and DVD players available to residents. There were laundry facilities available to residents in an outside shed attached to the residence.

Meals

Residents did not cook their own meals. Kitchen facilities were only available under supervision and use by residents was minimal. Staff undertook a general grocery shopping weekly and, while residents are free to partake, they tended not to do so. Residents with particular needs or preferences could have such requests included in the regular shopping.

Staffing levels (full time in residence)

STAFF DISCIPLINE	DAY WTE	NIGHT WTE
CNM2 (shared with other residences)	1	
RPN	1	1
MTA	1	

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

Team input (sessional)

DISCIPLINE	NUMBER	NUMBER OF SESSIONS
Consultant psychiatrist	1	On request
NCHD	1	On request
Occupational therapist	0	0
Social worker	1	On request
Clinical psychologist	1	On request
Other – CB Therapist	1	On request

Non-Consultant Hospital Doctor (NCHD); Cognitive Behavioural (CB).

The sector consultant with responsibility for the residence was newly in post and was currently evaluating and planning service needs. The sector team had no OT currently and this was hindering assessment of the needs and capacities of one of the residents. Access to members of the sector team was on a referral basis through the day centre. Brook House was one of a number of supported residences in the town and there was some sharing of staff between the various residences.

Complaints

There was no structured complaints system within the residence. Staff informed the inspector that there was a complaints box in the day centre and that any complaints lodged there would be addressed by staff with recourse to the assistant director of nursing (ADON), if necessary. There was no complaints log within the house. There was no information readily available indicating a complaints process or nominated complaints officer. Community meetings which could deal with complaints among other matters were held on a quarterly basis. There was no incident book available in the residence.

Medication

Regular prescribed medicine was supplied in dosette (a weekly tray of medication suitable for self-administration) boxes by a local pharmacy. Prescriptions were reviewed by the NCHD in the day centre and referred to the GP for a GMS prescription.

The Residence

The house was owned by a local mental health support group and was administered by the HSE. Each resident paid a rent of €90 per week (€30 of which went to St. Brigid's, Ballinasloe to fund heating costs, etc.). The rent paid covered both accommodations and food. Staff collected the rent from residents and provided a receipt for this. The inspector was informed that where a resident was temporarily absent (e.g. staying with family at Christmas) the only deduction made would be the €30 due to St. Brigid's.

Financial arrangements

Staff took the weekly rent from residents and a signed receipt was provided. Residents all had their own private bank or post office accounts and one or two had ATM cards. All residents managed their own money. There was no common fund within the house and outings or other expenditure was funded directly by residents.

Service user interviews

Only one resident was present in the house during the course of the inspection and did not wish to meet with the inspector.

Conclusion

Brook House was a 24-hour nurse staffed residence located on the outskirts of Mountbellew. Residents, some of whom have spent many years in the house, had access to a range of training and support outlets. The house was well maintained but would benefit from some physical renovation, particularly the bathroom areas. If any such renovation was undertaken, consideration should be given to auditing and minimising potential ligature anchor points. This is both in the interests of the present population but also in the context of the increasing use of the house to address shorter term respite needs of people encountering difficulties in a lower support location in the community.

Resident's clinical files held in the house did not have any systematic individual care plan. Residents' rehabilitation plans would benefit from a systematic and structured individual care planning process with active involvement of the resident in the process. Neither was there any systematic process for ensuring that regular six-monthly physical reviews were undertaken and documented.

While residents had their own rooms they had no means to secure their personal property.

The clinical team available to deal with residents' needs was deficient in that there was no OT available to the team to assess the needs of at least one resident. It was apparent during the inspection that nursing and MTA staff were engaged with the residents and supportive of their needs.

Recommendations and areas for development

1. *The residence would benefit from renovation of the bathroom facilities. If this was undertaken an audit of potential ligature points should be done and acted on when renovating.*

2. *Consideration should be given to facilitate residents with increased privacy, and security for their personal possessions.*

3. *Residents should have an individual care plan. This should be reviewed and updated by the multi-disciplinary team at regular intervals, with the direct involvement of the individual resident.*

4. *It was unclear that six-monthly physical reviews were being systematically undertaken and documented. It is important that the physical health needs of long-term residents not be overlooked and a structured process to ensure that regular physical review is undertaken should be developed.*

5. *The full resourcing of the multi-disciplinary team should be prioritised.*

6. *Consideration should be given to developing a structured and documented community meeting process and the maintenance of a discrete complaints log within the residence.*