Mental Health Services 2015

Inspection of 24-Hour Community Staffed Residences

COMMUNITY HEALTHCARE ORGANISATION	Area 9
MENTAL HEALTH SERVICE	Dublin North East
RESIDENCE	Carlton House
TOTAL NUMBER OF BEDS	10
TOTAL NUMBER OF RESIDENTS	9
TEAM RESPONSIBLE	Community Rehabilitation
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	24 February 2015
INSPECTED BY	Dr. Enda Dooley, MCN 04155, Assistant Inspector of Mental Health Services
ACTING INSPECTOR OF MENTAL HEALTH SERVICES	Dr. Susan Finnerty, MCN009711

Summary

- Carlton House was a 10-bed community residence located in a rural area of North County Dublin. It provided care with a rehabilitative focus to a cohort of residents with severe and enduring mental illness associated with variable chronic disability.
- The residence was in need of some renovation and redecoration
- Priority should be given to respecting and maximising the privacy and dignity of residents, particularly in relation to personal accommodation.
- All residents had an individual care plan (ICP). These plans should be critically reviewed to ensure that identified needs, goals, and necessary resources are currently relevant, that the review of such plans involves the entire multidisciplinary team (MDT), and that it is clear that the resident is centrally involved in such review.
- The MDT was not fully resourced and this should be addressed.

Description

Service description

Carlton House was a detached residence situated in extensive grounds in a rural area of North County Dublin approximately 6km from Swords. The residence was predominantly a bungalow with a two storey dormer section. It had functioned as a community residence for former patients of St. Ita's Hospital, Portrane since 2000. The residence functioned with a rehabilitation ethos.

Profile of residents

On the day of inspection, the residence was home to nine individuals, seven men and two women, aged from 42 to 64 years. There was one vacancy. The most recent admission occurred about 10 months prior to the inspection and one resident had been in the home since it opened in 2000. One resident was a Ward of Court and the remainder were voluntary. All residents had a history of severe and enduring mental illness and had been long-term patients of St. Ita's Hospital before moving to Carlton House. Three residents had a dual diagnosis of Learning Disability and Mental Illness but were under the care of the Rehabilitation team. All residents were fully mobile.

Quality initiatives and improvements in 2014-2015

- A number of residents now attend regular socialisation and other therapy programmes in Carriage House in Lusk.
- A Christmas family mass was organised which expanded contact with families and with other similar community residences.

Care standards

Individual care and treatment plan

The underlying ethos of the residence was on recovery and, if possible, movement to community residences with lower levels of support. Subject to staffing constraints, a key worker system was in operation. Clinical review meetings were held in the residence on a weekly basis, involving medical and nursing staff. In addition, all residents had an ICP contained in their clinical file. While the stated intent was to review these plans at regular intervals, and a schedule of review was available, it was not clear that a systematic review involving the MDT was in fact occurring. While it was stated that other team members - occupational therapist (OT) and social worker (SW) - would attend the ICP review this was not apparent from documentation relating to these reviews. In a number of cases there appeared to be little overall review of the ICP and no apparent direct involvement of the resident confirmed by documentation or signed acceptance of a copy of the ICP.

A formal, structured risk assessment was undertaken at time of admission and this was updated at time of review or otherwise, as required.

Staff presented as being proactive and supportive of residents.

Physical Care

All residents had their own GP in the community. There was a schedule of regular six-monthly physical reviews kept in the nursing office. Residents attended their own GP for these reviews and any necessary follow-up was arranged by the GP in consultation with the staff of the residence.

Residents were encouraged to partake in relevant screening programmes and this was facilitated by staff. Access to specialist services such as physiotherapy and dietician was through primary care.

Residents with out-patient appointments would generally be accompanied by staff.

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

Staff within the residence organised a variety of supportive programmes to help develop concentration spans. These included bingo sessions, newspaper review, crossword solution, and light baking. A number of residents went out to therapeutic programmes in the community on a daily basis. Three residents were currently attending the DELVIN programme in Balbriggan and others attended Carriage House in Lusk for a six week socialisation programme or for art classes. The residence had access to a multi-person vehicle (MPV) and this was used both to bring residents to external therapy programmes and also to facilitate outings at weekends and other times.

Residents had access to the house kitchen under supervision. Staff indicated that this tended not to be used. Some residents might prepare light snacks and one resident took pride in preparing occasional meals for others in the house.

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

A number of residents attended Mass in the local village and also a monthly community tea after mass. Staff indicated that the local community was supportive of the residents. Residents also attended events such as markets and outings to the cinema or shopping. There was a MPV available to the residence and this greatly facilitated access to the local community, given the relative isolation of the residence.

All of the residents enjoyed family support and a number received visits in the house. Others were facilitated in spending time with families in the community, either at weekends or for longer periods.

Facilities

Carlton House was a former private residence situated along a quiet road in a rural area. The house contained four single and three twin bedrooms. All, except one single bedroom, were en suite rooms. The twin rooms had no provision for privacy between beds. All rooms had adequate wardrobe and bedside locker space, together with shelf or drawer facilities. Residents did not have keys to their rooms and there was no facility for securing personal valuables within the rooms. Staff indicated that, while there was a safe available within the staff office for storage of any valuables, they generally advised residents to pass any valuables they might have to relatives for safe-keeping.

Residents were responsible for the cleaning and maintenance of the house and there was a roster of tasks on a notice board. Meals were prepared by staff within the house and, subject to their capabilities, residents assisted. Fridge storage facilities in the kitchen area were inadequate given the population, necessitating the use of an auxiliary fridge in the staff office to store milk

The residence had a utility room containing laundry facilities and there was a roster of availability for each resident.

The residence had undergone significant refurbishment in recent years and the flooring had been replaced throughout the common areas and bedrooms. The central hall area had been repainted. The bedrooms and sitting room required repainting and renovation. The house was warm with the exception of the conservatory area which was cold and poorly insulated. A number of bedrooms had en suite bathrooms which were internal and required significant renovation as they showed evidence of persistent damp with some mould on ceiling surfaces.

The extensive garden areas had recently been maintained by external contractors and provided both privacy and external recreation space to residents.

A small number of residents had their own mobile phone. A hands-free house phone was available to residents to receive or make calls on request.

Meals

Staff prepared meals for residents. Residents were encouraged to engage with this process and a number did depending on their capacities. While residents could express meal preferences there was no choice routinely available. Residents only had access to the kitchen under staff supervision. With the exception of one resident who enjoyed cooking other residents would use the kitchen only for drinks or light snacks.

Staff undertook food shopping weekly in a local supermarket and a number of residents enjoyed accompanying them on this task. Residents with particular food preferences could request specific items to be purchased and this would be done, where feasible.

Staffing levels (full time in residence)

STAFF DISCIPLINE	DAY WTE	NIGHT WTE
CNM2	1	0
RPN	1 - 2	1
HCA	1	1

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA)

Team input (sessional)

DISCIPLINE	NUMBER	NUMBER OF SESSIONS
Consultant psychiatrist	1	1 per week
NCHD	2	1 per week
Occupational therapist	1	On request
Social worker	1	On request
Clinical psychologist	0	0

Non-Consultant Hospital Doctor (NCHD)

The consultant psychiatrist and registrar visited the house on a weekly basis. Other members of the MDT were less readily available to the residence and, while it was indicated by staff that they would attend ICP review, this was not apparent from the records of such reviews. The MDT did not have any psychology input and this, potentially, impaired therapeutic planning and support to residents.

Complaints

There was no formal complaint log available within the house. Staff were not aware of any nominated officer to oversee or deal with any complaints arising. The HSE policy *Your Service, Your Say* was in operation. Staff indicated that they had no recollection of any complaints being made by residents. If this was to arise the complaint would be noted in the clinical file and brought to the attention of management, if necessary.

Staff indicated that informal community meetings were held within the house involving residents and these discussed issues such as possible outings and menu choices for meals. These meetings were not formally recorded or documented as the residents did not want this.

There was an incident book maintained in the residence and this was in order.

Medication

Medication was obtained from a local community pharmacy on a weekly basis. Prescriptions (including GP prescriptions) were written by the consultant or registrar and incorporated in a kardex system where administration was recorded. One resident was self-medicating using a weekly dosette system. The remaining residents were administered medication by staff. The kardex system was reviewed and found in order.

The Residence

The residence was owned by the HSE and had been in its present role since 2000. Each resident paid a weekly charge of €98. This covered bed, board, and services. Charges were either paid directly from residents accounts to St. Ita's Hospital or were collected by staff and transferred to the hospital. €50 per week per resident (currently €450/wk in total) was returned to staff by the hospital to cover food for the week.

Financial arrangements

Most residents now had their own post office accounts. A number of residents managed their own funds, though some required assistance from staff in relation to this. Staff held residents' cash in envelopes in the staff office and disbursed this as requested or agreed. An account was kept of money held and receipts were signed by both staff and residents for any money disbursed.

A number of residents were former residents of Woodview residence in St. Ita's Hospital and staff indicated that all of their funds were lodged and held by the hospital. These residents continued to be provided with €25-50 per week 'comfort' money by the hospital. Staff informed the inspector that there was no mechanism whereby these residents (or their families or next of kin) were routinely informed of their income and outgoings, together with funds held.

There was no common social fund held in the residence.

Service user interviews

A number of residents were met during the course of the inspection and were informed of the purpose of this inspection. No resident expressed any spontaneous complaint and none requested to speak with the assistant inspector.

There was no notice within the house giving information about available advocacy support and residents had no recent contact with any advocate.

Conclusion

Carlton House was a 10-bed community residence located in a rural part of North Dublin. It has been open since 2000. Residents had a history of severe and enduring mental illness with varying degrees of persistent disability. A number had a dual diagnosis of mental illness and learning disorder but were deemed to come within the remit of the Rehabilitation team.

Residents availed of a variety of therapeutic supports either within the house or at a number of locations around the north county. The residence provided transport to assist access. Residents had achieved a modicum of community engagement, taking into account the relative isolation of the residence.

A number of areas of the residence required physical renovation and redecoration. Residents would benefit from greater involvement in the day to day operation of the residence (preparation of meals, domestic maintenance).

ICPs were present in each file reviewed. It was unclear, however, from the documentation available, that a critical and systematic review of the needs and associated goals and resources required was undertaken, or that the resident was directly involved. The care plans reviewed did not indicate that all members of the MDT were involved in the review process. The MDT team was not currently fully resourced.

Recommendations and areas for development

1. *All possible steps should be taken to assist residents in fully engaging and partaking in the running of the house and in managing their own finances.*

2. *Reviews of the Individual Care Plans should be strategic and critically consider the current relevance of all needs and goals. Reviews should involve the entire clinical team and there should be clear evidence that the wishes and opinions of the resident are taken into account and that the resident is provided with a copy of his or her ICP.*

3. *Steps should be taken to safeguard and respect the privacy and dignity of all residents, particularly in relation to bedroom accommodation*

4. *Necessary renovation and re-decoration of the residence should be undertaken to ensure a comfortable and dignified living environment.*

5. *The Multi-Disciplinary Team should be fully resourced to ensure that residents have access to a comprehensive range of therapeutic interventions.*