Home Based Treatment Team 2012

EXECUTIVE CATCHMENT AREA/INTEGRATED SERVICE AREA	Kildare West Wicklow
HSE AREA	Dublin Mid Leinster
MENTAL HEALTH SERVICE	Kildare West Wicklow
NAME OF TEAM	North Kildare Home Service Team
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	22 May 2012

Summary

- The Home Care team operated as part of the community mental health team and was staffed by six mental health nurses.
- There was an excellent referral system, assessment procedure and individual care planning.
- A wide range of therapeutic interventions were available through the community mental health team and day hospital.

PROFILE OF SERVICE

The Homecare team was based in the sector headquarters in the Health Centre in Celbridge. The day hospital, the service for those with enduring mental illness (CNS team) and part of the multidisciplinary team were also located in these premises. The team consisted of six nursing staff.

The service operated during office hours, five days per week. However there was also a weekend service with two nursing staff. The team operated from one very small office in the health centre.

The homecare service assessed all referrals to the community mental health team with a view to management outside of a hospital setting.

Service users were referred from general practitioners, Accident and Emergency and other mental health services. Referrals were made by faxing referral forms to the mental health centre. Urgent referrals were made by phone and were seen immediately. Service users could be assessed at home or in the mental health centre.

CURRENT SERVICE PROVISION

All referrals were assessed using a bank of formal assessment tools including Functional Assessment of Care Environments (FACE), Hamilton depression scale, Positive and Negative Symptom Scale (PANSS) as well as screening for mania, anxiety and borderline personality disorder. Collateral history was also sought. Following these assessments and assessments by the consultant psychiatrists and other members of the multidisciplinary team, an individual care plan was initiated. The service user had input into the care plan.

Each service user referred to the team was allocated a key worker.

There was a range of interventions available such as dialectical behaviour therapy (DBT), family therapy, cognitive behavioural therapy (CBT), psycho-education, individual therapy with team members as well as medication management and referral to the day hospital if required.

Information about the Home Care Team and the community mental health team was available. The Home Care Team had built up a strong liaison with the general practitioners in the area.

GOVERNANCE

The Home Care Team operated as part of the community mental health team. Multidisciplinary team meetings were held once a week. There were policies in relation to the Home Care Team. An evaluation of the Home Care Team had taken place called Building Bricks.

On occasion the Home Care staff were asked to cover for lack of staffing in the day hospital which left the Home Care Team understaffed.

OVERALL CONCLUSIONS

The Home Care Team operated as part of the multidisciplinary community mental health team. Following an excellent referral system the service user underwent a wide range of formal and informal assessments which led to the creation of an individual care plan. The service user had input into the care plan throughout. A wide range of therapies were available for service users. This had resulted in a decrease in the number of admissions to in-patient care.

Of note was the fact that the staff on the Home Care Team were sometimes asked to replace nursing staff in the day hospital which meant that the Home Care Team was short staffed.

RECOMMENDATIONS 2012

1. Staff from the Home Care Team should not be requested to cover for staff shortages in the day hospital.