Mental Health Services 2011

Inspection of 24-Hour Community Staffed Residences

EXECUTIVE CATCHMENT AREA	Limerick, North Tipperary, Clare
HSE AREA	West
MENTAL HEALTH SERVICE INSPECTED	Limerick
RESIDENCE INSPECTED	Ferndale
TOTAL NUMBER OF BEDS	20
TOTAL NUMBER OF RESIDENTS	18
NUMBER OF RESPITE BEDS (IF APPLICABLE)	0
TEAM RESPONSIBLE	Rehabilitation
DATE OF INSPECTION	27 July 2011

Description

Service description

The Limerick Rehabilitation Team serviced a catchment population of 184,055. Ferndale Community Residence provided supervised residential care both for individuals requiring long term supported living and individuals who would progress to independent living. Ferndale Community Residence was located on a health and social care campus directly across the road from Limerick's Regional Hospital. The building was purpose built and had been operating as a mental health 24 hour nursing staffed community residence for 14 years.

Profile of residents

On the day of inspection there were 12 male and six female residents, ranging in age from 29 to 70 years of age. Individuals had been resident in Ferndale for between one month and fifteen years duration. The majority of residents had been resident for up to five years. All but one of the residents, were looked after by the rehabilitation team. An ethos of recovery and rehabilitation was clearly evident in the day to day life within the residence.

Quality initiatives and improvements in the last year

- A medication audit had been completed. Medication being stored on site had been reviewed and rationalised.
- All blood samples were taken on site for blood tests.
- A new individual clinical file had been designed and commissioned.
- Day Centres now returned a monthly feedback report for all residents attending and this was reviewed by the multidisciplinary team.
- A residents' community meeting had been set up. This was chaired and minuted by residents and the Irish Advocacy Network (IAN) advocate had been invited to attend. This meeting had generated a consensus on basic housekeeping and living arrangements required to make the house a good place to live for all.
- The format of the case file had been reviewed. A new individual clinical file was due to come on stream within a couple of weeks and this would incorporate a computer generated individualised label affixed to the top of each page. The ePEX computerised patient information system was operational.
- The local Mental Health Association had funded an array of recreational resources for the residents, including, DVD player, pool table, music centre, magnetic dart board, fuβball, chess and other table games.
- A structured programme had been introduced to support residents in becoming self-medicating. Residents brought their own prescription to a local pharmacy, paid the 50 cent dispensing fee and collected their own medication.
- Considerable progress had been made in setting up care pathways and links with local vocational and educational providers. This included individual assessment by the Occupational Guidance Service, Limerick Disability Services.
- Each resident had their own general medical practitioner whom they attended in the community.
- A CASIG (Client's Assessment of Strengths, Interests and Goals) rehabilitation needs assessment had been completed for each resident.

Care standards (based on Mental Health Commission- Quality Framework for Mental Health Services in Ireland 2007 and the 2008 inspection self-assessments)

Individual care and treatment plan

All residents had a multidisciplinary individual care plan (ICP). The care plans were based on a CASIG (Client Assessment of Strengths, Interests and Goals) Rehabilitation assessment and residents were fully involved in their own care planning process, signed their care plans and retained their own copy, if they wished to do so. Each individual clinical file inspected contained a resident profile sheet at the beginning of the file. This presented a concise psychosocial overview of the resident and it was easy to build up a picture of the resident as an individual and their values, lifestyle, relationships, health and rehabilitation needs.

The treatment plans specified activities and a care pathway and the resources required to deliver these. The Rehabilitation team met fortnightly from 0900h to 1300h and focused in-depth on individual care plans on a rotational basis, such that the ICP was reviewed approximately every six months or more frequently as indicated by assessed need. The resident, and with their consent, family members, attended the ICP review and were involved in the process.

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

At the time of inspection the majority of residents were off-site either attending rehabilitation or vocational programmes or engaged in individual pursuits. Each individual clinical file specified rehabilitation goals and interventions and contained a broad timetable. A couple of individual clinical files detailed a behavioural programme and contract, and this was reviewed regularly by the case manager and resident. Four residents attended Iniscarra Day Centre for the 12-week rehabilitation programme. Two residents attended the Vocational Training Centre at Raheen. One resident attended the Vocational training Centre at Newcastle. One resident attended the older persons group at Ger Griffin House Day Centre. Some residents dropped into the La Cheile, Mental Health Association Centre. One resident attended a National Learning Network Centre.

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

Residents were well supported in being involved in community activities and this was based on their individual care plan. Ferndale had established links and regular liaison with a number of voluntary and statutory agencies. These included, the National Learning Network, Rehab, Fas Training and Work Access, Focus Ireland Training Centre, AWARE, Le Cheile Mental Health Association Drop- in Centre , GROW, Irish Advocacy Network, The Inner Wheel Senior and Junior Groups, Alcoholics Anonymous and Al-Anon.

Family and friends were welcome to visit at any time. Some residents spent time and weekends at home with family. The residence was open and welcoming and persons who had previously been resident in Ferndale often dropped in to visit.

The residence had occasional access to a mini-bus for outings. All residents had their own bus pass and were independent in travel. The residence was well served by public transport.

Do residents receive care and treatment in settings that are safe, well maintained and that respect right to dignity and privacy

Staff and residents had made efforts to make Ferndale homely and bright. Bedrooms had been personalised with residents' belongings and pictures. Upstairs the decor was homely but dated. The sitting rooms were well-furnished with modern leather sofas and decor, and provided a relaxing and sociable environment for residents. The environment was well equipped with leisure and recreational

resources and at the time of inspection several residents were listening to music, playing pool, reading or having a cup of coffee. There was a small laundry room with washing machine, dryer and ironing board. Fourteen of the eighteen residents did their own laundry. The long corridor layout was somewhat institutional looking.

The residence did not provide an optimal rehabilitation environment:

- The kitchen was attractively fitted out but there were no facilities for residents to cook snacks or self-cater. This was regrettable in a rehabilitation setting where the promotion of basic independent living skills is paramount. The lack of a cooking facility within the living space undermined the written philosophy of Ferndale which stated "the focus of our rehabilitation recovery approach is on facilitating our clients in developing skills and providing supports to participate as fully as possible, in everyday activities and normal roles with their family/peers and within the community".
- Seven of the twelve bedrooms were twin-bedded rooms and this did not afford privacy. There was very limited storage space for personal belongings and for household and laundry storage.
- There were issues with ongoing maintenance. Blocked drains, which had been reported and for which maintenance was requested, remained unfixed and some of the lavatory areas were malodorous.

Staffing levels

STAFF DISCIPLINE	DAY WTE	NIGHT WTE
Nursing	1 CNM2 (Monday to Friday) 2 RPN (This complement of three staff may also include CNM1 grade). Activities Nurse 2 session per week	2 RPN
Housekeeping	2	0
Personal Care Assistant	1	0

Team input

DISCIPLINE	
Consultant psychiatrist	1
NCHD	1
Occupational therapist	1
Social worker	1
Clinical psychologist	0

Describe team input

The above table represents the number of staff in post at the time of inspection.

Sessional multidisciplinary input varied according to client need. A number of individual clinical files were inspected and evidenced good regular input from the multidisciplinary team (MDT). Medical reviews were regular and a report was sent promptly to relevant stakeholders, such as GPs. The NCHD was on-call during office hours. An MDT review meeting was held fortnightly. A key worker or care manager system operated and this role was assigned to whichever MDT team member had the most appropriate expertise to support the individual resident. The post of clinical psychology remained vacant.

Medication

All prescription sheets had been recently re-written and were legible, however, Medical Council Registration Numbers (MCRN) were not used by the prescribing doctors. Ten residents were prescribed more than one anti-psychotic, and of these, four were prescribed three different anti-psychotics. Less than 50% of residents were on regular day-time benzodiazepines. In one instance, a medication had been discontinued but there was no date or signature indicating when this had been done. Medication was prescribed by either the consultant, the NCHD or the GP. Five residents were self-medicating and there was a structured programme in place to enable more residents to manage their own medication. There was written information on medications available to residents. Residents generally brought their own prescription to a local pharmacy to be filled. There were lockable cupboards for residents to store medication.

Depot injections were administered on-site and blood samples were taken on-site as required. Ferndale had a policy of spot-check drug screening.

MEDICATION

NUMBER OF PRESCRIPTIONS:	17
Number on benzodiazepines	8 (47%)
Number on more than one benzodiazepine	0 (0%)
Number on regular benzodiazepines	8 (47%)
Number on PRN benzodiazepines	7(41%)
Number on hypnotics	4(24%)
Number on Non benzodiazepine hypnotics	3(17%)
Number on antipsychotic medication	15(88%)
Number on high dose antipsychotic medication	0(0%)
Number on more than one antipsychotic medication	10(59%)
Number on PRN antipsychotic medication	4(24%)
Number on Depot Medication	4(24%)
Number on antidepressant medication	5(29%)
Number on more than one antidepressant	0(0%)
Number on antiepileptic medication	9(53%)
Number on lithium	4(24%)

Tenancy rights

Each resident had been registered on the Local Authority Housing List with a view to future placement. Ferndale was owned by the HSE and there were no tenancy agreements. Residents paid a flat rate of €60 per week to cover accommodation and board. The main meal was prepared off-site at St. Camillus's Hospital and delivered in a heated trolley and served up by household staff. Several residents had encountered challenges in adapting to budgetary management so as to afford clothes, cigarettes if smokers, and leisure pursuits. Staff supported residents in this regard. A small amount of petty cash was held on site to be accessed daily or weekly as wished by residents. All residents had their own post office account and four had their own bank account. Many residents had monies held on account with the HSE and financial statements were issued regularly and these were held in the individual clinical files. The inspector requested that financial records be held in a separate file.

General housekeeping and ground rules for communal living issues were discussed at regular community meetings held weekly in Ferndale. The local IAN advocate had been invited to attend these meetings. Residents served up their own breakfast and tea and there was a duty rota for this activity.

A complaints log was kept on site and inspected. The log featured a couple of minor complaints that had been responded to and resolved immediately. The complaints procedure was posted on a notice board in the hallway.

Financial arrangements

Each resident had their own post office account and four residents had their own bank account. All residents had the capacity to manage their own monies. Staff handled petty cash and kept a cash account book which was counter signed by the resident. This account book was overseen in the first instance by the CNM2 and then by an off-site HSE administration office. There were clear policies and protocols in place in relation to monies.

Leisure/recreational opportunities provided

Ferndale had secured funding from the Mental Health Association, a voluntary group, for the purchase of recreational resources within the house. These included, a pool and table tennis, table games, a music centre, an electronic games consol, magnetic darts and a Fuβball table. Residents were encouraged to pursue leisure and recreational activities in the community. Regular outings were arranged at the community meeting.

Service user interviews

All residents on-site were greeted by the inspector. No resident wished to speak individually with the inspector. In general conversation, all residents encountered expressed satisfaction with living in Ferndale, with the food and care, with the community meeting and with how living arrangements were agreed and felt staff were very approachable and supportive. A couple of residents stated that single room accommodation was desirable. It was evident in conversation that residents felt supported and empowered to pursue their own goals.

Conclusion

Ferndale impressed as being recovery oriented in its ethos and staff attitudes. The potential for realising rehabilitation and recovery goals was hampered by the institutionally high bed numbers, the lack of single room accommodation and the absence of a kitchen facility for residents to prepare snacks and to self cater if they wished. There was an evident balance between facilitating individual autonomy and respecting communal needs. This had been achieved by individual care planning with the resident at the centre of the process, with community meetings, clear communication and informed risk management.

Recommendations and areas for development

1. The number of residents should be halved to a maximum of ten persons as per A Vision for Change Recommendations.

2. All accommodation should be in single rooms.

3. The building should be maintained and requests for maintenance responded to in a timely manner. A log should be kept and be reviewed by senior management.

4. Involvement of a service user advocate should be progressed and supported as planned and implemented.

5. The writing of prescriptions should meet best practice standards.

6. Resident' financial records and correspondence should be kept in a separate file rather than in the individual clinical file.

7. A service user kitchen facility should be provided within Ferndale residence, so as to allow residents to make hot drinks and snacks and to develop independent living skills.