Mental Health Services 2015

Inspection of 24-Hour Community Staffed Residences

COMMUNITY HEALTHCARE ORGANISATION	Area 8
MENTAL HEALTH SERVICE	Longford/Westmeath
RESIDENCE	Glenavon House
TOTAL NUMBER OF BEDS	11
TOTAL NUMBER OF RESIDENTS	9
TEAM RESPONSIBLE	General Adult
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	26 February 2015
INSPECTED BY	Patricia Doherty, Assistant Inspector of Health Services
ACTING INSPECTOR OF MENTAL HEALTH SERVICES	Dr. Susan Finnerty, MCN009711

Summary

- Glenavon community residence provided supervised, continuing care to residents discharged from an approved centre or other community residences.
- The premises was old and unfit for purpose as a mental health facility. It was planned to refurbish the building and the HSE was preparing documents for tender.
- A Rehabilitation and Recovery team was recruited recently and this team was due to take over responsibility for residents in the near future.
- Individual care plans were not used. Nursing care plans were medically rather than recovery focussed and did not reflect the range of services available to residents.

Description

Service description

Glenavon community residence was built in 1932. It consisted of two adjoining 4-bedroom houses with interconnecting doors and combined back and front gardens. Situated in a suburban area, it was near a bus stop and within easy reach of the centre of Athlone town. It was opened as a mental health residence in 1988 and operated as a continuing care facility. The house was dated and in a poor state of repair. One bedroom was decommissioned as a leaking roof had resulted in damage to the ceiling. Staff reported that plans were at an advanced stage for the development of a purpose-built facility on the site which was due to open in 2016.

A rehabilitation team had recently been established and on the day of inspection, members of the team were meeting on-site to plan the development of a rehabilitative service in the residence.

Profile of residents

On the day of inspection, there were five male and four female residents aged 38-76 years. All were voluntary status and there were no Wards of Court.

Two additional beds were available for respite care and the early discharge of residents from the approved centre when beds were needed there. Staff reported there were three or four of these latter types of admission annually. On the day of inspection, these beds were not in use.

All current residents had been discharged from the approved centre or medium support residences which had closed. The most recent admission was in 2010 and there had been no recent discharges. Residents were ambulant and there was one bedroom downstairs to facilitate the admission of anyone who was not. There was evidence in the clinical files that some residents had co-morbid physical conditions.

A Quality initiatives and improvements in 2014-2015

- Members of a Rehabilitation and Recovery team had been recruited during the year. A clinical nurse manager (CNM2), ten staff nurses, three multi-task assistants, a psychologist, occupational therapist and social worker had been employed. Staff reported that application for approval for a consultant psychiatrist post in Rehabilitation and Recovery had been made.

- Refurbishment works were planned. To that end, a design brief was prepared, an architect was appointed and the remaining members of the Design Team were in the process of being appointed.

- Staff had participated in the roll-out of the *Eolas* programme, an information and learning initiative for people with severe mental health difficulties and their families.

- Staff were trained to provide WRAP (Wellness Recovery Action Plan) programmes. They had participated in *Decider Skills* training (aimed at providing cognitive behaviour therapy (CBT) and dialectic behaviour therapy (DBT) based skills for individuals and groups with mental health problems).

Care standards

Individual care and treatment plan

Residents had nursing, but not multidisciplinary, care plans. These tended to be medically oriented and reflected the complex physical needs of the residents. There was evidence in the nursing continuation notes of a recovery orientation to care, with the inclusion of information on the development and maintenance of social skills and on the socialisation of residents. Residents were encouraged to maintain contact with their families and go into town. They shopped for their own clothes and did their own laundry in the house. Each resident had a day when they could stay at home, look after their personal care, and participate in activities of daily living (ADLs). They attended a recently opened Health Service Executive (HSE) mental health day centre, about a mile away from the residence. They travelled there by HSE transport and could walk back each day, weather permitting. The care plans did not reflect this level of activity and to that extent under-reported on the variety of experiences available to the residents.

Separate nursing notes were held in the day centre. Staff reported that care was formally integrated at the monthly multidisciplinary care planning meeting. In addition, informal contact was made regularly between staff in the residence and day centre.

Residents were reviewed every three months in the out-patient department by the consultant psychiatrist. Nursing notes were maintained separately to the main clinical file which contained medical and multidisciplinary notes.

In the case of one clinical file reviewed, the three-monthly review had been missed and the resident had not been seen by a psychiatrist for fifteen months. It seemed from enquiries made on the day of inspection that, when the resident unavoidably missed one appointment, further appointments were not sent. The oversight was not noticed as nursing staff did not look at the separate medical files

Physical Care

Residents attended their own general practitioners (GPs) and had individual medical cards. Staff reported that residents attended their GPs regularly, however, there was no evidence on the day of inspection, that residents were receiving regular physical examinations. The assistant inspector was informed that a protocol for the introduction of six-monthly reviews was being developed by the Rehabilitation and Recovery team. Staff subsequently reported that this was not intended and the current system of GP care would be continued.

An on-call medical service was provided by a GP out of hours service. Some medical entries in one clinical file from this service were not signed or dated.

Residents had access to the services of a dietician and speech and language services through the Primary Community and Continuing Care (PCCC) programme. They were accompanied, if necessary, by a staff member to out-patient appointments.

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

Residents had access to the kitchen to make tea and coffee at any time during the day. Staff reported that some residents who liked cooking were encouraged to participate in cooking activities, or make their own meals in accordance with their individualised programme.

Residents attended a HSE mental health day service one and a half miles away. Staff reported that most residents attended. On the day of inspection, four residents remained in the house. One resident was doing art work with a nursing student.

Each resident was encouraged to take one day a week for themselves in the residence, when it was quiet, to attend to their own affairs in the house or in the town and benefit from individual attention from nursing staff. Each resident had their own laundry basket and was encouraged to look after their laundry themselves. A keyworker system was in operation which facilitated this.

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

Staff reported that most residents were in contact with their families, some of whom lived nearby. Residents visited their homes, sometimes stayed overnight there, or went on outings with family members. They did not participate in local groups but several were well known in town and had contacts there whom they met when they went shopping. There was a cinema in town and residents occasionally went there. In summer, group outings were arranged to places of interest. Group outings were sponsored by the local Mental Health Association and by the Simon Community.

Facilities

The residence was old and in a poor state of repair. There was evidence of structural damage to the premises which staff reported was the result of subsidence. It was in urgent need of redecoration, with peeling paint in several places, however, staff reported that because the building was due to be refurbished, this was not being done. Three of the four bathrooms were refurbished in 2014 and were in good condition. One bathroom light fitting was dirty, as was the kitchen in places. A toilet seat was broken.

One bedroom was not being used because a leaking roof had caused damage to the ceiling.

Single bedrooms were comfortable and some were personalised by residents. This had not been done in some rooms and these were bare and institutional looking. There were three twin bedrooms. There was no privacy for residents in those rooms. One bedroom upstairs was only accessible through another room. Staff reported the interconnecting door could not be locked for fire safety reasons.

The dining area was pleasant and bright. Meals were prepared in the residence by multitask attendants.

There were two sitting rooms which were comfortable and pleasantly decorated. They were small and staff reported there was inadequate space in these rooms when the residence was full.

On the day of inspection, the assistant inspector was shown the locked medication storage press in the laundry room. Subsequently, staff reported that medication was stored in a clinic room.

Meals

Food was bought in the local shop and meals were prepared on the premises by multi-task attendants. There was no choice of main meal. Special diets were catered for. Staff reported that, where residents indicated they did not like a particular dish, an alternative was provided. They indicated that because the residents were well known to the staff, so were their preferences. Staff reported that numbers of residents in the house during weekdays varied between three and six.

Staffing levels (full time in residence)

STAFF DISCIPLINE	DAY WTE	NIGHT WTE
CNM2	1	0
Staff Nurse	1 x1330h-2130h and 1x0815h-1615h	1
MTA	2	1

Clinical Nurse Manager (CNM), Multi-task Assistant (MTA)

Team input (sessional)

DISCIPLINE	NUMBER	NUMBER OF SESSIONS
Consultant psychiatrist	1	0
NCHD	1	0
Occupational therapist	1	As needed
Social worker	1	As needed
Clinical psychologist	1	As needed

On the day of inspection, residents were under the care of the general adult mental health team, although this was about to change as staff for a Rehabilitation and Recovery team had just been appointed.

Psychiatric reviews were conducted by the consultant psychiatrist in the primary care centre every three months. An on call GP provided out of hours medical cover. Dietetic, speech and language and diabetic nursing services were accessed through the PCCC services.

A shared CNM2 was available at night.

Complaints

Staff reported that issues that arose were dealt with by the CNM2. A complaints box was displayed, but staff reported complaints were rare. Copies of *Your Service Your Say,* outlining the HSE complaints procedure, were not on display.

A community meeting was held every 4 to 6 months and staff reported issues were also dealt with there. Minutes were kept and seen by the inspector. No separate complaints record was kept.

In the case of incidents, report forms were sent to the Director of Nursing and discussed at the Health and Safety Committee. The CNM2 participated in this committee and lessons learnt were brought back to the residence from this. Staff reported there were no major incidents in the residence in the year to the date of inspection.

Staff reported that a representative of the Irish Advocacy Network did not visit as the post was vacant.

Medication

Psychotropic medications were prescribed by the psychiatrists and reviewed three-monthly or sooner, on request. Medication for general health issues was prescribed by the residents' GPs. All medications were delivered from the local community pharmacy. Nursing staff checked deliveries against prescriptions to reduce risk of errors being made. They administered medication as required.

There was no self-medication programme.

The Residence

The house was owned by the HSE. Each resident was charged €60 per week for food and utilities. Most residents paid by bank standing order.

Financial arrangements

All residents had their own bank accounts which they managed themselves. Small amounts of cash which they withdrew were held in individual purses, in a locked press. Withdrawals were signed for by two nursing staff and the resident. Group activities were paid for by individuals from their own funds. A kitty system was not used.

Service user interviews

A number of service users were spoken to during the course of the inspection. They spoke about the quality of the food, relationships with staff and family. All said they were happy in the residence.

Conclusion

Glenavon community residence provided continuing care for long stay residents who had either been discharged from hospital or other residences, which had closed. The building was old, in a poor state of repair and décor, and plans were advancing to have it refurbished.

Nursing, multidisciplinary and day centre clinical files were separate. There were no multidisciplinary individual care plans. Nursing care plans tended to be medically focussed and under-reported the level of recovery oriented activities that took place. There was no evidence in the residence on the day of inspection that physical examinations were routinely done. Some clinical notes from the on-call GP service were not signed or dated.

The service was in transition and about to be handed over to the Rehabilitation and Recovery team who had recently been recruited. On the day of inspection, the team was meeting in the residence to develop policies and protocols for the new service that would be provided.

Recommendations and areas for development

1. *The building was not fit for purpose as a modern mental health facility and refurbishments should take place as soon as possible.*
2. *The rehabilitation team should assume responsibility for the residence as soon as possible.*
3. *All residents should have routine physical reviews and a record that these were done should be maintained in the clinical files.*
4. *Multidisciplinary care plans should be adopted and regularly reviewed by the mental health team. They should reflect a Recovery approach to care.*
5. *All entries made in the clinical file by doctors must be signed, dated and include the doctor's Medical Council Registration Number.*
6. *Clinical files should be integrated.*
7. *The kitchen and one bathroom should be thoroughly cleaned.*
8. *The damaged toilet seat should be replaced.*
9. *Copies of 'Your Service, Your Say' should be displayed.*