Mental Health Services 2014

Inspection of 24-Hour Community Staffed Residences

EXECUTIVE CATCHMENT AREA/INTEGRATED SERVICE AREA	Dublin North
HSE AREA	Dublin North City / St. Vincent's Hospital, Fairview
MENTAL HEALTH SERVICE	Dublin North
RESIDENCE	Grace Park, Dublin 9.
TOTAL NUMBER OF BEDS	11
TOTAL NUMBER OF RESIDENTS	11
NUMBER OF RESPITE BEDS	Nil
TEAM RESPONSIBLE	Community Mental Health Sector Teams / Rehabilitation
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	11 December 2014
INSPECTED BY	Dr. Enda Dooley, Assistant Inspector, MCN004155
ACTING INSPECTOR OF MENTAL HEALTH SERVICES	Dr. Susan Finnerty, MCN009711

Summary

- Grace Park was a 24-hour staffed community residence in the Drumcondra area which had been open for many years. It provided a supportive living environment for a group of residents suffering from long-term mental illness.
- The physical maintenance and décor of the residence left much to be desired and could best be described as 'jaded.' Management were aware of this deficit and plans were in train to move to an alternative location in the vicinity subject to the allocation of finance to allow necessary alterations to the proposed location.
- Staff were proactively involved with residents but integration with the responsible Community Mental Health Sector teams appeared to be lacking.
- Individual Care Plans (ICPs) showed little evidence of multidisciplinary involvement and there was no clear pattern of review and revision.

Description

Service description

This three-storey residence was composed of two adjacent houses which had been amalgamated into one unit. One of these houses (No. 4) was privately owned and was leased by the HSE while the other (No. 5) was directly owned by the HSE. This led to some inconsistency in the maintenance of both properties. The residence was located on a quiet cul-de-sac of similar red-brick terraced houses in Drumcondra and had been open for many years. It accommodated a number of long-stay residents who were supported by the Rehabilitation service and Community Mental Health Sector teams based in St. Vincent's Hospital, Fairview. Where possible, patients would move to a medium support residence but this occurred infrequently.

Profile of residents

Residents ranged in age from 45 to 77 years. Most had been resident for a considerable period. The most recent admission was in 2012 and one resident had been living in Grace Park since 1995. On the day of inspection there were three males and eight females living in the residence. All were voluntary. While staff commented that the average age of residents had increased, and that this had been accompanied by increasing medical problems, all residents remained mobile with the exception of one resident who required accommodation on the ground floor. Staff indicated a philosophy of maximising and maintaining autonomy and independence amongst a group of long-term residents with a history of enduring and significant mental illness.

Quality initiatives and improvements in 2013-2014

- Staff had developed an afternoon therapy group involving residents in newspaper review, crosswords, and music appreciation.
- A number of residents attended a Social Support programme in the day centre in St. Laurence's Road.
- Recently, the attachment of a St. Vincent de Paul (SVP) volunteer to the residence had facilitated the befriending of a number of the more socially isolated residents and their improved socialisation through accompanied visits to social events.

Care standards

Individual care and treatment plan

Residents had a care plan documented in their clinical file. This was not a single composite document but a variable number of separate and isolated care issues exclusively reviewed and monitored by nursing staff in the residence. There was little evidence of multidisciplinary involvement in these care plans. Residents were all admitted under a responsible consultant psychiatrist based in St. Vincent's Hospital, Fairview. A key worker system was in operation. Staff indicated that mental health reviews were undertaken through the resident attending the relevant outpatient clinic. Frequency of attendance was variable depending on the needs of the particular resident. There was minimal evidence that any of the multidisciplinary teams (MDTs) ever met in the residence and staff confirmed that they only had the opportunity to attend the MDT meeting of one of the four responsible teams when workload within the residence allowed. Staff indicated that any direct involvement by other members of the MDTs was by specific request in relation to a particular resident. Risk assessments were carried out on admission and thereafter as indicated, given the progress and any difficulties encountered by the resident.

All residents had their own GP within the local community and attended either on their own or with staff assistance, if required. The clinical files held within the residence did not have systematic documentation of the undertaking of regular physical reviews and there was no system apparent to act as a reminder that such reviews were due. Staff indicated that routine physical review of residents might be undertaken either by the general practitioner (GP) or by responsible mental health team but that feedback was inconsistent and generally focussed on further interventions required.

Staff in the residence presented as motivated and engaged with the residents. There was a continuity of staff which facilitated knowledge of residents' needs and possible difficulties.

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

The daily operation of the residence was coordinated by nursing and care staff. There was little evidence of regular input from other disciplines. Staff facilitated a number of afternoon groups aimed at socialisation and orientation. While residents had the facility to undertake their own laundry, the location of the limited facilities available often necessitated staff assistance. Residents did not have access to the kitchen and meals were prepared by staff. A weekly menu was on display. There was no routine choice of meal but staff indicated that the chef would facilitate any personal request or need, if possible.

Residents attended their own GP for physical issues. This could be undertaken independently or with staff assistance, if required.

A number of residents attended external support services (Basin Club, Blessington St.), either travelling independently or utilising hospital transport (to attend the social support club in the day centre in St. Laurence's Rd.). No residents were currently engaged in formal training opportunities.

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

A small number of residents enjoyed family support and went out with family members. All residents were free to go out when desired but staff reported that, due to the chronicity of their disability and increasing dependency, it was difficult to motivate many residents to do so. There was no planned schedule of recreational or other outings available. The residence was located in a residential area close to a variety of amenities.

Facilities

The overall standard of accommodation and maintenance was poor. With the exception of a sitting room and one bedroom (in house No. 4) there was no evidence of recent decoration or routine maintenance. In many areas there was evidence of paint peeling off the walls and of dampness. One house (No. 4) had a small outdoor area which was paved and showed little evidence of regular use. The outdoor area in house No. 5 was used as a smoking area. It also housed (in an external shed) the laundry facilities (washing machine and separate drier) fir the residence. This facility was open and showed evidence of leakage. The dining room area was divided in two sections and could best be described as functional. The kitchen, which was not available to residents, was in need of significant renovation.

Meals were prepared by a chef who was available on a 5/7 day part-time basis. At other times, meals were prepared by staff. The residence also had house staff support for cleaning and cooking purposes. Once a week, a ward clerk from St. Vincent's Hospital visited to deal with household and individual finance matters.

There was a comfortable sitting room on the ground floor of House No. 5. This had TV, DVD and radio, together with a variety of books readily available. It was decorated for Christmas and was homely and welcoming. It was used in the afternoons for group activities organised by staff. House No. 4 had a separate sitting room on the first floor. This had been repainted and renovated by the landlord and was a comfortable room. It facilitated TV, music, and reading. Residents had free access to a payphone or could have their own mobile phones though only a small number did so.

Resident accommodation was a mixture of single and twin rooms located on all three floors. All residents had individual wardrobes, cupboards, and bedside lockers which were lockable by the resident. Residents kept the key to their lockers. Throughout both houses, it was apparent that the storage space available to residents was inadequate, necessitating quantities of personal possessions being stored on bedroom floors in black plastic sacks or other containers. Twin-bed rooms had inadequate provision for personal privacy. In some rooms, residents had personalised their accommodation with photos and other decorations.

Toilets and bathrooms were located at various points throughout the premises. In general, the standard of decor and maintenance was poor and there was evidence of ligature anchor points in various facilities. Bathroom areas could be locked and, if necessity arose, locks could be over-ridden by staff.

The overall décor and maintenance of this residence could best be described as 'jaded'. There was no evidence of significant renovation and routine maintenance appeared to be reactive. Apart from two areas mentioned above, there was no indication of redecoration of living areas for considerable time.

Staffing levels

STAFF DISCIPLINE	DAY WTE	NIGHT WTE
CNM1 / CNM2	1	0
RPN	1	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	-	-
NCHD	-	-
Occupational therapist	-	-
Social worker	-	-
Clinical psychologist	-	-

The CNM 1 and 2 roles partially overlapped. The residence had no regular multidisciplinary team input. Members of the MDT visited at specific request, where applicable, to undertake specific assessments. Residents attended out-patient clinics in the community. In addition to the nursing staffing outlined above, the residence had input on a 5-day basis (10-4pm) from a nurse allocated to a local community residence from where a number of residents (3) attended Grace Park during the day. The residence had a chef on a 5-day part-time basis to prepare main meals and also had household staff input on a part-time basis. A ward clerk from St. Vincent's Hospital attended once a week to deal with both household and individual financial matters.

Medication

Medication was prescribed either by GP or by the responsible mental health team. A kardex administration system was in operation. Medicines were supplied by a community pharmacy and were held in the clinical room. Residents did not manage their own medication. Depot injections were administered by staff and clozapine dispensing and monitoring was undertaken through St. Vincent's Hospital, Fairview. During the inspection there was no medication related information readily available in a user-friendly format.

Tenancy rights

All residents were charged a flat rental of €90 per week. This included food and utilities. The residence did not have any communal social fund. Staff indicated that a monthly communal meeting was held at which residents could raise issues regarding the running of the house. There was no written guidance available regarding a formal complaints procedure and there was no written record available of any complaints made by residents.

Financial arrangements

Residents all had their own post office or bank accounts. Where necessary, due to limited capacity or other disability, staff assisted residents in managing their financial affairs. While staff did handle monies, all residents were issued with receipts for items such as charges and pharmacy levies.

Service user interviews

No service user expressed a wish to meet with the inspector on an individual basis. A number of individuals, who were greeted during the course of the inspection by the inspector, expressed their satisfaction with staff and the routine within the residence.

Conclusion

Grace Park was a 24-hour staffed community residence providing accommodation for 11 residents with a history of chronic and enduring mental illness. Staff turnover was low and input from the responsible Community Mental Health Sector teams was limited. The facility was in need of major renovation and redecoration. In addition, there should be focus on therapeutic inputs to assist residents in maximising their autonomy and independence. In spite of the physical limitations of the residence, it was apparent that staff were engaged with residents, and were supportive in assisting residents to engage with community mental health and social inputs.

There were difficulties with décor and dampness throughout the building. Lack of adequate storage for personal possessions was also apparent and gave rise to clutter in some rooms. It was indicated that the lack of suitability of this residence had been acknowledged and a plan was in place to move to an alternative residential location in the vicinity. Implementation of this move awaited the allocation of resources to enable modification of the identified community residence. This was currently under negotiation with area management.

Recommendations and areas for development

1. *The residence requires major refurbishment and redecoration if it is to continue in its present role.*
2. *Residents would benefit from a more structured therapeutic programme to maximise their autonomy and independence.*
3. *Clinical files should contain a single ICP which should indicate clearly the inputs from various disciplines of the MDT and indicate a regular multidisciplinary review process.*
4. *Staff from the residence should be facilitated in having a greater involvement in MDT meetings pertinent to the needs of residents.*