Mental Health Services 2013

Inspection of 24-Hour Community Staffed Residences

EXECUTIVE CATCHMENT AREA/INTEGRATED SERVICE AREA	Carlow, Kilkenny, South Tipperary
HSE AREA	South
MENTAL HEALTH SERVICE	Kilkenny
RESIDENCE	Kincora
TOTAL NUMBER OF BEDS	14
TOTAL NUMBER OF RESIDENTS	13
NUMBER OF RESPITE BEDS	0
TEAM RESPONSIBLE	Rehabilitation
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	20 August 2013

Summary

- Kincora residence was located in a residential area on the outskirts of Kilkenny city. The residence was difficult to identify as it was situated on a roadway behind bollards and had no nameplate or signage.
- The Rehabilitation team had responsibility for Kincora residence. Each resident had an individual care plan that was rehabilitation focussed and reviewed regularly. The Rehabilitation team was very poorly resourced with health and social care professionals and this undermined the rehabilitation process. At the time of inspection, there was no occupational therapist, no clinical psychologist and no social worker on the rehabilitation team. In essence the team comprised a single handed consultant psychiatrist and nursing staff who were to be commended for the service delivered to residents.
- The residence was well maintained and was bright and cheerful. Residents should be accommodated in single rooms rather than twin-bedded rooms.

Description

Service description

Kincora, a high support residence, was located in a residential area on the outskirts of Kilkenny city. The residence was difficult to identify as it was situated on a roadway behind bollards and had no nameplate or signage. The building was not purpose built and had previously been a private home that had been extended, before opening in the 1990s as a 24-hour nurse-staffed residence. The provision of a large nurses' station at the entrance corridor and the floor covering made for a rather clinical and institutional environment. Other than that, the residence was comfortable and homely, and two pet cats were in residence. The two storey building had good-sized grounds.

The Rehabilitation team had responsibility for the care and treatment of residents. There were clear admission criteria for any person being admitted to the care and support of Kincora residence. The stated ethos at Kincora was to provide a non-aversive, non-judgmental, proactive environment and a person-centred approach to help residents establish personal responsibility for achieving mental health recovery. Residents had a structured daily routine, generally involving activities outside the house and there was a pathway whereby residents might be discharged to other community based accommodation.

Profile of residents

Residents ranged in age from 55 to 80 years old. On the day of inspection there were six female residents and seven male residents. Residents' needs were varied both in mental health and physical health terms. As residents became older physical illness and mobility issues became a feature. Several residents had significant mobility and physical health issues and required nursing, palliative care and medical care. All residents were voluntary, several having moved into Kincora from St. Canice's Hospital after a lengthy hospitalisation there. One resident was in the process of being made a Ward of Court.

Quality initiatives and improvements in 2012/2013

- A medication audit had been completed by peers in the Carlow mental health service and a rate of 99.8% accuracy was noted.
- Two bathrooms had been refurbished.
- New matching sets of curtains and bed-linen had been purchased for each bedroom.
- New TVs had been purchased.
- The house was painted recently.

Care standards

Individual care and treatment plan

Each resident had a detailed individual rehabilitation care plan. Plans were devised with each individual resident's input central to the process and this was well recorded. Individual care plans were reviewed at least every three months by the multidisciplinary team (MDT). There was also a fortnightly MDT review meeting and any additional issues arising were discussed then. Most residents signed their care plan. Psychiatric reviews were completed every six months or more frequently if required. Each resident had their own GP who completed the six-monthly physical examination. The Clinical Nurse Manager liaised with GPs and made a note of the physical review outcome and filed any relevant documentation in the individual resident's file. There were seven GPs who provided care for the residents of Kincora. Residents had access to community physiotherapy, occupational therapy, dietetic and palliative care services as required. At the time of inspection, the rehabilitation team accessed occupational therapy and social work input as required from the sector teams. The occupational therapy post was subsequently filled. CareDoc an on-call GP service provided the out-of-hours service to the residents.

The scope of the ICPs was rehabilitation and recovery focused and each resident had a clearly identified schedule of activities. There was a psychosocial profile sheet for residents and excellent needs assessment, including risk assessment. The use of standardised tools in this regard aided MDT discussion and outcome evaluation.

Each resident's clinical file was well organised and it was easy to retrieve information and to track progress. Discussion with nursing staff in relation to the residents showed that the staff were committed, professional and energetic in their approach. Staff had good knowledge of the residents, including their interests and preferences, and also their families. The interaction observed between residents and staff was warm and open.

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

Residents variously attended Brook Centre, a day centre based on the St. Canice's Hospital campus, or St. John's Day Care Centre, run by a community group, at St. John's Church in Kilkenny, or the Alzheimer's Society Day Centre, or pursued individual activities within Kincora or within the community.

There was a bio-psychosocial profile completed for each resident and this highlighted preferences, daily routines, pursuits and family and social relationships. Each resident's individual file contained a weekly schedule of activities and pursuits. When pursuing activities in the community, residents were driven to their destination in the Kincora multi-person vehicle or paid for taxis themselves.

The absence of an occupational therapist (OT) currently on the MDT meant that functional assessments and tailored individual OT programmes to facilitate independent living skills were not available to residents. This undermined the rehabilitation programmes available and the pathway to independent living. Management subsequently advised that the OT had returned from leave and this service was now available to residents.

Residents assisted staff in completing the weekly household shop but did not have the opportunity to cook or assist in cooking.

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

Residents were actively supported to pursue social activities within the community and to maintain contact with their families. As many residents had been in-patient in St. Canice's Hospital for a considerable length of time and as the age profile of residents was getting older, several residents required support and transport to do so. The residence was located on the outskirts of the city and was not on a direct bus route. Residents variously went to Mass, played bingo, went to the pub, to the cinema, to social functions in the old age community centre and to visit family.

Facilities

Sleeping accommodation was in eight single-bedded rooms and three twin-bedded rooms. Bedrooms had wash hand basins. Bathrooms and lavatories were located separately on the corridor. Privacy was respected throughout and there were curtains in place to facilitate this. Some residents were used to sharing sleeping accommodation owing to having been living in a health care facility for some time, however, the standard should be single-room accommodation for all.

The premises were clean and tidy. Housekeeping staff looked after laundry and general housekeeping. Residents were facilitated to participate in these activities insofar as practicable. Residents looked after their own bedroom space.

Catering staff looked after all meals which were freshly cooked in the kitchen. The menu was varied, nutritious, catered for special dietary needs as required and included healthy options. The community meeting generated ideas for menus and residents told the inspector that the food was good.

Staff stated that maintenance support was good and was provided by the maintenance staff at St. Canice's Hospital. Two bathrooms had been refurbished and staff stated that this work had been contracted and supervised by the maintenance staff but purchased out of the Kincora household account monies.

The entrance hallway featured a hospital style nurses' station reception desk which made for an institutional feel to the residence.

Staffing levels

STAFF DISCIPLINE	DAY WTE	NIGHT WTE
CNM2 (4 days per week & 1 Sunday a fortnight)	1	0
RPN	1	1
Housekeeping	1	0
Catering	1	0

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Non Consultant Hospital Doctor (NCHD).

Team input

DISCIPLINE	NUMBER	NUMBER OF SESSIONS
Consultant psychiatrist	1	As required, fortnightly review meeting
NCHD	0.5	Post vacant at time of inspection, since filled
Occupational therapist	0.8	Post vacant at the time of inspection, post holder since returned
Social worker	0	Input sought from sector teams if required
Clinical psychologist	0	Input sought from sector teams if required

Medication

Psychotropic medication prescriptions were written by the consultant psychiatrist and were transcribed by the treating GP onto a medical card (GMS) prescription sheet where applicable. The GP wrote all other prescriptions. A single pharmacy in the community dispensed all medications and delivered medications to Kincora on a monthly basis. Where there were changes in prescribed medications during the month, nursing staff collected medication from the pharmacy. Nursing staff administered all medications. No resident was self-medicating. Depot injections were administered in Kincora and Clozapine medication was administered at the day hospital at St. Canice's Hospital.

Tenancy rights

There was a policy and procedure for the management of residents' monies. A local bank manager had visited the residence and met with residents on an individual basis to inform them of banking options and to answer questions. All residents were in receipt of a pension or disability allowance. These monies were lodged directly into residents' personal accounts either in a bank or credit union account. Residents paid the Health Service Executive (HSE) a flat rate of €75 per week for bed and board. This money was paid either by standing order or in cash by each resident and was lodged to the Kincora household account in a local bank. The CNM2 managed this account and it was audited by the administration office based in Carlow HSE offices. The Kincora household account was used for all housekeeping costs, including utilities. Residents did not sign a tenancy agreement. Staff reported that the Kincora household account had funded refurbishment of two bathrooms in the residence, the purchase of a TV, house-painting and new bed linen.

There was no social fund or kitty operating within the residence. Residents could contribute on an optional basis to social occasions such as birthdays, outings and parties.

There was an excellent record of each resident's financial transactions in relation to Kincora, both their bed and board contribution and if a resident kept any monies as petty cash. Two nurses signed receipts in relation to petty cash. Only small amounts of money were kept in the residence.

The complaints procedure was well signposted within the residence. A weekly community meeting was held and the proceedings were recorded in a book. These minutes were inspected and were well recorded and in detail. Most issues of dissatisfaction were resolved via the community meeting before the issues became complaints. There was also a complaints log and this was inspected.

Financial arrangements

All residents were in receipt of either a pension or a disability allowance. Some residents were in receipt of an "incentive allowance" of €13 which was a throwback to the time when long stay residents were paid a stipend for industrial therapy. The majority of residents looked after their own personal finances and had both bank accounts and credit union accounts. One resident in particular, who was in the process of being made a Ward of Court, required support in this regard and two nurses countersigned all transactions relating to this resident and this was regularly audited by HSE administration staff.

Service user interviews

The independent advocate visited Kincora every eight weeks and contact details were posted in the event that a resident wished to make contact between visits. The individual care plans indicated that all residents were fully informed and involved in their own care planning process. It was evident that rehabilitation pathways had been discussed and agreed with each resident and family where appropriate. Care pathways included nursing homes, medium support hostels and intellectual disability services.

Residents were greeted by the inspector during the course of the inspection visit and all residents encountered expressed satisfaction with their care and living in the residence. Interaction between staff and residents was observed to be warm and open.

Staff maintained a resource folder with information for residents and families on aspects of mental illness, medications and voluntary groups.

Conclusion

The Rehabilitation team had responsibility for Kincora residence. Each resident had an individual care plan that was rehabilitation focussed and reviewed regularly. The Rehabilitation team was very poorly resourced with health and social care professionals and this undermined the rehabilitation process. At the time of inspection, there was no occupational therapist, no clinical psychologist and no social worker on the team. In essence the team comprised a single handed consultant psychiatrist and nursing staff who were to be commended for the service delivered to residents. The weekly Rehabilitation team review meeting was attended by staff from the various community residences and this facilitated excellent communication and integration across the rehabilitation service.

Recommendations and areas for development

1. Sleeping accommodation should be in single rooms.

2. The rehabilitation team should be adequately resourced with health and social care professionals.