Mental Health Services 2011

Inspection of 24-Hour Community Staffed Residences

EXECUTIVE CATCHMENT AREA	Dublin North East
HSE AREA	Cavan/Monaghan, Louth and Meath
MENTAL HEALTH SERVICE INSPECTED	Cavan
RESIDENCE INSPECTED	Lisdarn Lodge
TOTAL NUMBER OF BEDS	15
TOTAL NUMBER OF RESIDENTS	14
NUMBER OF RESPITE BEDS (IF APPLICABLE)	3
TEAM RESPONSIBLE	Rehabilitation Team
DATE OF INSPECTION	17 February 2011

Description

Service description

This staffed residence was located in a stand-alone two storey house in the grounds of Cavan General Hospital. The service was established in 1995 and the pre-existing building was renovated for the purpose. Admissions were arranged by the general adult teams. Referrals were also accepted from the assertive outreach team, for respite care and relapse prevention.

The front entrance was somewhat secluded and the alternate entrance was dusty and there were cobwebs across the door. Many of the residents had been there since the building opened and staff were unaware of any plans to move the residents to alternate accommodation. In addition to the long-stay residents, respite care was provided to three relatively younger residents.

Inside, the building showed signs of age and staff reported that maintenance which had been requisitioned had not been carried out.

Staff reported that rehabilitation activities had become more difficult as the residents got older so that the service had become one of continuing care, rather than rehabilitation.

Residents' clothing was labelled and laundry was for the most part done in situ for the residents. However, because household staff were not always there, this was sometimes done by the nursing staff. Nursing staff reported that this was less time consuming than completing the various forms that would be required if the laundry was to be done in the general hospital laundry department.

Profile of residents

There were 15 residents, 10 male and five female. The age range of the long-stay residents was 53-87 years. Staff reported an increase in the amount of physical care required due to the age range of the residents. While there, one of the two staff nurses on duty was engaged in helping residents to shower.

The age of people admitted for respite care was 23-50 years at the time of inspection. Nursing staff reported that they tended to be younger and fitter than the long stay residents who were sometimes at risk of being knocked over in the corridors by people who walked faster than them.

Staff reported that residents could leave the unit alone or with relatives or staff as arranged in their care plans. Because of their age, some residents needed assistance. Permanent residents were less likely to go out, according to staff.

Quality initiatives and improvements in the last year

- A smoking room had been decommissioned during the year and another bedroom had been development in its stead. No alternative smoking arrangements had been made for smokers who had to go outside, sometimes at night to smoke. Staff reported that the area was somewhat secluded and open to the public and expressed concern for their own safety as well as that of residents.

Care standards (based on MHC Quality Framework and 2008 inspection self-assessments)

Individual care and treatment plan

Multidisciplinary care planning meetings took place annually and individual care plans were written up for the following year. These plans were signed by the residents. However, it was unclear from one file examined whether recommended interventions had been carried out and who was responsible for doing this.

Every resident had their own general practitioner (GP) who was responsible for undertaking annual physical reviews. Staff reported that for the most part, residents attended GPs in community clinics. Where they did not, residents were reviewed by the GP in the residence and this was entered into their clinical file. A list system was in operation to identify when physical examinations were due. There was no evidence of a physical examination being done in the case of one resident whose file was reviewed. Bloods were sent on a six-monthly basis to the hospital laboratories. If a problem was identified, residents were referred to the GP.

Psychiatric reviews were conducted by the senior registrar approximately every four to five months. Staff reported that psychiatric staff could be contacted sooner if needed.

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

Residents did not attend any day hospital, day centre or for the most part a training or education facility. There was evidence in the clinical files that members of the multidisciplinary team were involved in patient care and that residents had been referred for specialist general health services. Referrals had been made to rheumatology and physiotherapy. One resident had been referred for behaviour therapy. One respite resident was trying to access a FAS course with the help of nursing staff on the day of inspection. He had been referred by the occupational therapist. However, it was not always clear from the notes whether residents had received recommended services.

There was no dedicated activation nurse. Staff reported that occupational therapy was provided only to respite residents. Staff reported there was no art therapy available to residents. They reported they did physical exercises, quizzes and reality orientation with residents when possible.

Staff informed the Inspectorate that the FACE risk assessment tool was used in the service. In one clinical file examined, a risk assessment had been done, but was not signed.

There was no computer or internet access for staff or residents to enable them to access relevant information for patient use. Staff reported this had been applied for, but refused.

Staff reported that a representative of the Irish Advocacy Network had visited the service once.

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

On the day of inspection, staff reported that most of the long-stay residents would not be able to access local facilities or shops without a staff member present. They said that because of staff shortages, it was not possible for most residents to access outside facilities. The nearest bus stop was in the town, about 15 minutes walk away. When families visited, they sometimes brought their relative out. Local music groups came into the facility on special occasions and the residents enjoyed a sing-song when this happened.

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

The building was old and in need of modernisation and maintenance. There was evidence of paint peeling in the corridors and plasterwork had fallen off the ceiling in one bedroom. Floor covering was torn in places. A request had been made by staff for maintenance. The living room and kitchen areas were bright and welcoming as were some of the bedrooms.

The exterior of the building looked neglected. While there was a substantial green area around the house which was maintained by the hospital, this was not private to the residents. There was no developed garden space. A patio area was uneven and a potential risk to residents who were older.

There were four double and five single bedrooms. All had their own wash-hand basins and wardrobes (except one which was being developed). The double rooms did not have curtains between the beds for privacy. Staff reported that the rooms were not suitable for such divisions and if erected, would adversely affect the atmosphere in the rooms, making them more clinical.

A fire drill had been held on 7th February 2011 and fire alarms had been checked. Staff had a record of this.

A Management of Risk Policy was available, but had no date. The HSE Complaints Policy was available and the service had a complaints box. Staff reported no complaints had been received. Other policies specific to Lisdarn House were not available to the inspectorate on the day of inspection.

Staff reported that incidents and near misses were dealt with locally, but were unaware of the mechanism for addressing these more broadly within the organisation.

Staffing levels (full time in residence)

STAFF DISCIPLINE	DAY WTE	NIGHT WTE
Nursing (RPN)	2	1
Attendants (HCA)	1-2	0

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Non Consultant Hospital Doctor (NCHD),Health Care Assistant (HCA)

Team input (sessional)

DISCIPLINE	NUMBER OF SESSIONS
Consultant psychiatrist	Annually
NCHD	As required
Occupational therapist	As required
Social worker	As required
Clinical psychologist	As required
Other – Behaviour Therapist	Behaviour therapist one day per week

Describe team input (team meetings/outpatient appointments)

Staff reported on the day of inspection, that team meetings were held in Cavan General Hospital and were attended by the multidisciplinary team (MDT). Residents from Lisdarn Lodge were only discussed in the event of a problem arising. Staff reported that multidisciplinary services were mainly availed of by respite residents.

The Inspectorate was subsequently informed that in addition, staff held a quarterly multidisciplinary meeting for all hostel residents.

Medication

Prescriptions for physical conditions were provided by the residents' own GPs. Prescriptions for mental health conditions were provided by the patient's consultant psychiatrist or the senior registrar. Depot injections were administered in the residence by nursing staff.

The residence used a card index system which had a separate section for PRN (as required) medication. There was not enough room on the sheet for regular medications and these had spilled over into another section. The sheets were untidy and the signatures illegible. Medical Council Registration Numbers were not used. There were no indications documented for PRN medication. A third of residents were prescribed more than one antipsychotic medication.

MEDICATION

NUMBER OF PRESCRIPTIONS:	14	%
Number on regular benzodiazepines	1	7%
Number on more than one benzodiazepine	0	0
Number on PRN benzodiazepines	5	35%
Number on benzodiazepine hypnotics	1	7%
Number on non benzodiazepine hypnotics	1	7%
Number on PRN benzodiazepines	3	21%
Number on antipsychotic medication	12	86%
Number on high dose antipsychotic medication	2	14%
Number on more than one antipsychotic medication	5	36%
Number on PRN antipsychotic medication	5	36%
Number on Depot medication	2	14%
Number on antidepressant medication	5	36%
Number on more than one antidepressant	0	0
Number on antiepileptic medication	5	36%
Number on Lithium	1	7%

Tenancy rights. Do community meetings take place?

There were no tenancy agreements in place. Several residents had lived there for many years and staff reported that they felt the residence was their home.

Community meetings did not take place. Staff reported that a CNM2 met with residents to discuss issues of concern to them.

A complaints box was available on one of the corridors. However, it was not identified. There was no documentation in evidence about the procedure to be followed for making a complaint.

Financial arrangements (policy, procedure, capacity)

Rent was deducted from each resident's income in the finance department of St. Davnet's Hospital. An allowance of €35 was paid to each resident who then had to pay €15 toward food. A small amount of money was kept for each resident and an account was kept of money paid out of this. Receipts were provided. Additional money was available from the finance department for other living expenses e.g. clothes. However, residents also had to pay for their taxi if they wanted to go out. Staff were unaware whether money for rehabilitation purposes was available.

The Inspectorate was informed that this was done in accordance with the Health (Inpatient Charges) Regulations 2005 and that each individual was assessed in accordance with their financial needs.

Leisure/recreational opportunities provided

Leisure and recreational opportunities were limited. Staff reported insufficient personnel and budgetary resources were allocated to allow them to both accompany the elderly residents on outings and at the same time facilitate the care of those residents who remained in the residence**.** On the day of inspection, staff reported that a minibus, to which they had access until recently, had been withdrawn.

A TV, DVD and books were available in the sitting room.

Following the inspection, the inspectorate was informed that this minibus was still available to the service.

Service user interviews

A number of residents were spoken to on the day of inspection and all expressed satisfaction with their care. Residents seemed to have a good relationship with nursing staff.

Conclusion

The service provided to residents of Lisdarn House appeared to be isolated, institutionalised and neglected. The sitting area needed to be painted and there was evidence of peeling paint in the corridor. With the exception of the nursing staff, there was little input from the multidisciplinary team. There were few recreational or therapeutic activities. Staff were under the impression that a minibus to which the residence had access had been withdrawn, although this was not the case. There was little relationship between the residents and the general community. The building itself was old and in need of maintenance and modernisation. Despite the availability of the surrounding grounds, there was no garden. A bedroom had been developed during the year at the expense of the residents' smoking area which had not been replaced.

Respite residents had been referred to the service in order to facilitate early intervention and in the hope of avoiding acute hospital admission. However, the suitability of the facility for such a case mix must be questioned. Given its institutional nature, the level of stigma for younger people admitted should be considered.

Recommendations and areas for development

1. *The advisability of mixing long term residents with younger, fitter respite residents should be reviewed.*

2. *Maintenance should be improved and the general decor of the residence modernised.*

3. *A proper garden area should be developed for use of the residents.*

4. *The staff member responsible for interventions identified in individual care plans, should be identified.*

5. *All documentation should be signed.*

6. *Representatives of the Irish Advocacy Network should be encouraged to visit on a regular basis.*

7. *Money for rehabilitation purposes should be identified.*

8. *Prescriptions should be audited.*