Home Based Treatment Team 2010

EXECUTIVE CATCHMENT AREA	Cavan Monaghan
HSE AREA	Cavan Monaghan
CATCHMENT AREA	Monaghan
MENTAL HEALTH SERVICE	Monaghan Adult Mental Health Services
NAME OF TEAM	Home Based Treatment Team
TYPE OF INSPECTION	Announced
DATE OF INSPECTION	5 May 2010

PROFILE OF SERVICE

The home based treatment team in Monaghan was set up in 1998. It provided acute psychiatric care for service users in their own home. It operated seven days a week from 0830h until 1930h. The service was provided by nursing staff and medical staff. There were two consultant psychiatrists, an Assistant Director of Nursing who was the community mental health team co-ordinator, five clinical nurse specialists, one community support worker and administrative support two days per week. The headquarters consisted of one large meeting room and two small offices and was located in St. Davnet's Hospital, Monaghan. Clinical files were kept on the premises and these files were fully integrated.

PROFILE OF SERVICE USERS

The home based team provided acute psychiatric care for people from 18 years to 65 years. Eighty per cent of people referred to the service were treated at home by the team. The team also provided family support and education to relatives and carers. There were approximately 20 people on the case load but this number was flexible. In 2009, 188 people were assessed and treated by the home base treatment team. Each service user was seen at least once a week by the medical staff and was followed up at home by the nursing staff. Service users were discharged to outpatient departments.

CURRENT SERVICE PROVISION

Service users were usually assessed by a nurse and a doctor in St. Davnet's Hospital although this assessment could be done in the service user's home if necessary. Emergencies were seen within two hours of referral and there was no waiting list. There was an individual care plan developed for each service user following assessment. The service user did not sign it nor did they receive a copy of the individual care plan. There were team meetings twice a week. Referrals to social work and psychology were made through the weekly community mental health team meetings. Medication was either dispensed by the community pharmacist or could be administered by the nursing staff if necessary. Discharge summaries and plans were documented. There was an information booklet that contained information about the home based team.

There was a good relationship with general practitioners in the area. A survey had been initiated to ascertain the views of the local general practitioners about the service.

The home based treatment team were involved with the Cavan home based treatment team, in setting up a programme called Care in Overcoming Psychosis (COPE) which would provide an early detection service for people with psychosis.

GOVERNANCE

The team used the service wide policies. However they also had team specific policies which covered Admission, Discharge and other aspects of the team. There were regular business meetings. The team were currently collecting data on age profile, diagnosis and admissions. There was some anxiety expressed for the future of the service in light of the acute admission unit moving to Cavan and it appeared that there had not been much communication to staff about this. While no written plan for the service was available staff had communicated the need for a day hospital service and further respite beds.

OVERALL CONCLUSIONS

The Monaghan home based treatment team had been in operation for twelve years. It provided an excellent service for people with acute psychiatric illness and had succeeded over the years in keeping admissions to the inpatient unit to a minimum. It also allowed for early discharge of service users from the acute unit. The fact that emergency referrals were seen within two hours meant that general practitioners concerns were responded to immediately. Record keeping was excellent.

RECOMMENDATIONS 2010

1. Service users should sign and receive a copy of their individual care plan.

2. A five year plan for the home based service should be available and future plans for the service communicated to staff.