Mental Health Services 2015

Inspection of 24-Hour Community Staffed Residences

COMMUNITY HEALTHCARE ORGANISATION	Area 6
MENTAL HEALTH SERVICE	Dublin South East/Wicklow
RESIDENCE	Morehampton Lodge
TOTAL NUMBER OF BEDS	16
TOTAL NUMBER OF RESIDENTS	16
TEAM RESPONSIBLE	4 Sector Teams
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	18 February 2015
INSPECTED BY	Liam Hennessy, Assistant Inspector of Mental Health Services
ACTING INSPECTOR OF MENTAL HEALTH SERVICES	Dr. Susan Finnerty, MCN009711

Summary

- Morehampton Lodge was a striking three storey, red brick semi-detached house located at the corner of a busy junction in Dublin 4 with good access to public transport.
- There were positive relationships between residents and staff, although the rostering arrangements for nursing staff militated against the building of such relationships.
- A number of residents were engaged in therapeutic programmes outside of the house. However, some residents felt that the programmes they attended were repetitive and their attendance was simply to comply with the contract they had signed on entry into the facility.
- Three residents were in bed at the time the inspection took place, which was mid-morning.
- The physical configuration of the residence potentially represented a fire hazard.
- Urgent remedial work was needed for most of the bathrooms and the utility room.

Description

Service description

Morehampton Lodge, a three storey semi detached dwelling, is located in Dublin 4. Formerly a B and B, it was opened as a Health Service Executive (HSE) 24 hour staffed high support community residence for persons with mental illness in March 2004.

The focus of care, according to staff, was moving from a philosophy of care and support to one of rehabilitation and greater integration of residents into the community.

Profile of residents

There were 16 residents in the house at the time of inspection, one of whom was on leave. There were 12 male and four female residents who ranged in age from 32 to 69 years. Most of the residents living in the facility were there on a long term basis.

All residents were voluntary and there was one resident who was a Ward of Court. Residents were fully mobile and did not need any assistance with activities of daily living. However, a number of residents were in bed at the time of inspection which took place mid-morning.

Quality initiatives and improvements in 2014-2015

- The service was proposing to dedicate two beds specifically to the operation of a Recovery focussed philosophy of mental health.
- The service had introduced new short term contracts for new residents designed to promote the Recovery philosophy and earlier discharge from the facility to a lower level of supported care.
- The service was involved in the Advanced Recovery in Ireland (ARI) Project in the community. This was an initiative to support seven Irish mental health services in their effort to implement a number of key concepts – especially the Recovery model – in line with a *Vision for Change.* Service users in the residence and their family members have participated in the EOLAS Project since 2014 (The EOLAS Project has developed and is delivering a peer and clinician led mental health information programme on recovery from the experience of mental health difficulties).

Care standards

Individual care and treatment plan

The facility was migrating to the recovery ethos. Each resident had an individual care plan (ICP), although the level or extent of resident involvement in their preparation or assessment was unclear. The plans were placed on the nursing notes which were separate from the clinical files. While the plans contained three elements – problems, goals and assessments – recording of assessments and multidisciplinary team involvement, insofar as it took place, appeared in the clinical files. There was no explanation for this dichotomy.

There was a full assessment of each resident every four months and an evaluation every two to three months although it was not clear how these interventions differed.

A key worker system was in operation. However, given the staff rotation and rostering procedures, the key worker role effectively defaulted to the clinical nurse manager 2 (CNM 2) who was the only clinical staff member present in the facility on a full time basis.

Each resident was seen by the consultant psychiatrist from their sector team at least once a year, while the registrar on the relevant team visited weekly. A designated consultant for hostels attended the hostel on a weekly basis and reported back to the sector teams. Insofar as could be determined and taking account of the fact that many residents were offsite at the time of inspection, staff were positive in their interaction with residents. It was a concern that three residents were in bed at the time of inspection which took place mid-morning.

Physical Care

All residents had their own GP and attended independently for renewal of prescriptions, originating with the non-consultant hospital doctor (NCHD) attached to the relevant sector team, as well as other physical health matters. In fact, some eight GPs in all provided services to residents including six monthly physical examinations. Access to screening programmes and to other services, if required, was available to residents.

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

Some, but not all, residents were engaged in an activity or programme outside the residence. This reflected a commitment given in the contract of engagement with the service which each resident agreed to on referral to the facility. Thus, up to eight residents attended a local day centre for activities such as social skills training, relaxation and health and fitness programmes. Residents also attended Glenmalure Day Hospital for assertiveness training and other recovery focussed programmes as well as participating in a Gateway programme. One resident was taking a business skills course at Rosyln Park, a Rehabilitation facility. However, the assistant inspector was informed that the residents found the Gateway programme repetitive and were “fed up with it”.

There were no specific therapeutic programmes being conducted in the residence itself. Residents were, however, supported with activities of daily living (ADLs). In particular, residents cooked evening meals, the cooking being carried out on a rota whereby every resident had one full day in the kitchen. Residents were encouraged to cook meals of their choice having ordered the ingredients themselves on a collective weekly shopping list.

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

The house was located on a busy main street with a mixed residential and commercial profile. There was excellent public transport and a number of local coffee shops and pubs. A nearby pub in particular was used by residents. The staff of the pub knew the residents very well and facilitated responsible drinking by residents of the house.

Residents had the use of a minibus for outings to the cinema and other venues. Moreover, the residents themselves sometimes organised trips to venues such as the National Concert Hall.

Facilities

The house comprised 13 single and three double rooms, all en suite. Only one double room was occupied on the day of inspection.

The communal areas of the house - the sitting room, the kitchen and a small visitors' room - were well maintained, even if the ambience was somewhat drab and dated with heavy brown furnishings.

The bedrooms were reasonably well maintained and residents were encouraged to personalise them with photographs, pictures, other mementos and ornaments. However, in some cases, the personalisation of rooms had reached almost hoarding dimensions which might pose a fire risk.

The condition of the en suite bathrooms was very poor in all cases with flaking paint on ceilings and cracked or missing floor tiles. In one room - room number 12 - this presented a clear health and safety risk. The assistant inspector was informed that these defects had been notified to the relevant maintenance authorities in the HSE on a number of occasions. To date, however, no remediation works had taken place, although such works – the assistant inspector was subsequently informed - had been scheduled since January 2015 to begin in the third quarter of 2015. The replacement/refurbishment work will take place on a rolling basis.

The laundry room comprised a wooden shed/extension at the back of the residence where the paint on the wood was visibly peeling and the floor and wall planking appeared to be deteriorating, if not actually rotting. This could also pose a health and safety risk. The assistant inspector was subsequently told that tenders were being sought for the improvement of the laundry facilities.

The garden was not developed as a garden – the only input was from a strictly maintenance perspective which amounted to no more than spraying for weeds a couple of times each year. This represented a lost opportunity for the provision of a worthwhile leisure and therapeutic space. However, the service indicated subsequently to the assistant inspector that residents who attended the day centre were involved in a garden project. The intention is that, when such residents have acquired sufficient horticultural skills, the garden project will be extended to Morehampton Lodge.

Overall, the residence presented a warren-like configuration of rooms with narrow corridors. All corridors had fire doors of a single person size and fire drills were conducted to mitigate fire risk which the configuration of the rooms appeared to pose. However, it was noted that the premises are inspected annually by the HSE Fire Officer and an upgrade of the emergency fire equipment has been scheduled for completion in the third quarter of 2015.

Meals

Residents cooked evening meals, the cooking being carried out on a rota whereby every resident had one full day in the kitchen. Residents were encouraged to cook meals of their choice having ordered the ingredients themselves on a collective weekly shopping list. There was open access to tea and coffee making facilities.

Staffing levels (full time in residence)

STAFF DISCIPLINE	DAY WTE	NIGHT WTE
CNM 2	1	0
RPN	1	1
HCA	1	1
Household staff	1.5	0

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA),Multi Task Assistant (MTA)

DISCIPLINE	NUMBER	NUMBER OF SESSIONS
Consultant psychiatrist	4 (1 from each of the sector teams) 1 designated as hostels consultant	At least once a year Weekly
NCHD	1	Weekly
ADON	1	Visits daily
Occupational therapist	0	0
Social worker	1	As needed
Clinical psychologist	1	As needed

Assistant Director of Nursing (ADON)

Team input

Four consultant-led sector teams had responsibility for the care of residents. Each resident was seen by his or her consultant at least once a year and on other occasions, where deemed necessary. The NCHD attached to the relevant team visited weekly. A designated consultant for hostels attended the hostel on a weekly basis and reports back to the sector teams. A designated ADON visits daily including weekends. There was good evidence of the involvement of social workers in the clinical notes but little evidence of the involvement of other allied health professionals.

Nursing staff, other than the CNM2, were rostered to work in a number of different facilities in the area – a practice which militated against the building of relationships with residents.

Complaints

Complaints were made directly and verbally to the CNM2 and there was no complaints log as such. The CNM2, however, noted complaints made by a resident on his or her clinical file. Regular community meetings, which were minuted, were another avenue whereby complaints could be dealt with.

The assistant inspector sought a copy of the HSE policy on complaints *Your Service Your Say* as it did not appear on the rack of information leaflets. The policy was not provided.

An Incident Report book was maintained but was very difficult to read as the imprint on the carbon copies was very indistinct.

Notwithstanding this, the assistant inspector became aware of one serious incident recorded in the incident log. The incident arose as a by-product of self-medication protocols being operated by a number of residents. It involved the finding in a bin in the nursing office of a box of clozaril medication which had been mistakenly identified as being empty. The incident was investigated and discussed at the MDT meeting.

Medication

Five residents were on self-medication programmes which involved the distribution of blister packs of medications for a week's duration from a locked safe in the nursing office. The remaining 11 patients received their medication under direct supervision by nursing staff.

All prescriptions, originally written up by the NCHD, were then transcribed onto a GMS form by the resident's GP. The prescriptions were collected centrally.

The Residence

The house was owned by the HSE. Residents paid charges of €100 each per week. The charges were not individually determined and all residents paid the same rate.

The residence was run on the budget from weekly charges which funded all expenses of the running costs and food other than replacement of essential infrastructure.

Community meetings took place regularly and provided a forum where, amongst other things, complaints could be aired and action taken to resolve them. Other than the minutes of these meetings, there was no composite centralised recording of complaints. Complaints were, however, noted by the CNM2 on the clinical files.

Financial arrangements

All residents had their own post office accounts and HSE charges were paid by standing order. Staff in the residence did not handle money. Most residents received disability benefit and each resident had a personal safe.

There was no social fund or kitty as such, although the assistant inspector was informed that informal collections did take place to fund birthday and other celebrations for residents. These collections were conducted by the residents themselves.

Service user interviews

The assistant inspector spoke to a number of residents during the inspection. All appeared satisfied with their care and the facility itself and one resident went so far as to say "it was the best I've ever had". On being introduced to residents by the CMN2, it was clear that there was a good relationship with the CNM2 – arising from their obvious commitment and the fact that they were the only member of clinical staff who worked in the residence on a full time basis.

Conclusion

Morehampton Lodge was a striking three storey, red brick semi detached house located at the corner of a busy junction in Dublin 4 with good access to public transport. It had previously been a B and B and the assistant inspector was informed that members of the public still came to the facility seeking overnight accommodation notwithstanding the fact that it had been in HSE ownership since 2004.

The configuration of rooms in the house - particularly on the second/attic floor - was challenging and warren-like with narrow corridors. This may pose a fire risk, a possibility that was apparent to staff. As a result, the facility was attempting to mitigate the risk through single size fire doors and regular fire drills.

There were 13 single and three twin rooms in the residence all of which had en suite bathrooms. Only one of the twin rooms was occupied on the day of inspection. There was absolutely no privacy in this room for the two residents concerned. The inspector was informed that the room was being used as a temporary measure to accommodate two residents. These residents had been transferred with little notice following the condemnation of another HSE facility where they previously resided.

Almost all the bathrooms in the house were in poor and, in one case even possibly, dangerous decorative order.

The public areas were spacious and well provided with furniture and fittings, even if some of the furniture was dated and of a dull and heavy brown colour.

Four sector teams had clinical responsibility for residents and all residents had ICPs. However, the ICPs were kept separately from the clinical notes so that the limited involvement of members of the relevant MDT was not reflected in care plan assessments or evaluations although recorded on the clinical files.

All residents paid the same weekly charges of €100 without any apparent individual assessment. The Health Service Executive National Guidelines on Charges for In-Patient Services advocates that each resident be assessed for individual allowances which may affect the weekly charge.

Recommendations and areas for development

1. *Individual care plans should be kept on one composite file and show evidence of resident involvement in their preparation and monitoring unless a resident choses not be involved.*
2. *All residents should be accommodated in single bedrooms.*
3. *Planned remedial work in relation to all bathrooms showing signs of deterioration of fittings should be expedited*
4. *The wooden utility/laundry facility should be replaced.*
5. *The garden should be developed as a potential therapeutic space.*
6. *The house should be refurbished, where necessary.*