Mental Health Services 2015

Inspection of 24-Hour Community Staffed Residences

COMMUNITY HEALTHCARE ORGANISATION	Area 7: Kildare/West Wicklow, Dublin West, Dublin South City and Dublin South West
MENTAL HEALTH SERVICE	Dublin South Central
RESIDENCE	Mountain View, Ballyfermot
TOTAL NUMBER OF BEDS	17
TOTAL NUMBER OF RESIDENTS	17
TEAM RESPONSIBLE	Rehabilitation Community Mental Health Team
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	20 January 2015
INSPECTED BY	Dr. Fionnuala O'Loughlin MCN 08108, Assistant Inspector of Mental Health Services Liam Hennessy, Assistant Inspector of Mental Health Services
ACTING INSPECTOR OF MENTAL HEALTH SERVICES	Dr. Susan Finnerty, MCN 009711

Summary

- Mountain View was a recently constructed, purpose-built residence for 17 residents who required long-term, continuing care.
- All residents had an individual care plan.
- Most residents were under the care of the rehabilitation team. This team was insufficiently resourced with medical staff and health and social care professionals. It had 1 x 0.5 Whole Time Equivalent (WTE) social worker and no psychologist.
- There was no choice of meal for the main meal of the day, except on a Friday.
- Due to a number of anti-social incidents in the immediate surrounds of the residence (not involving residents), a security person had been retained and was on duty nightly for a number of hours.
- There was no signage indicating the location or nature of the facility although this had been requested by the service.

Description

Service description

Mountain View was a recently constructed, purpose-built residence situated just off the Ballyfermot Road in west Dublin. It was located adjacent to a Primary Care Centre and its garden backed onto the Cherry Orchard Hospital campus. There was no identifying notice or name on the building.

The building was a two-storey residence, attractively designed and well maintained. It opened in 2011 and most of the residents were transferred to this residence from a community residence in Crumlin. Inside, the residence was sub-divided in three, but there was free access to each house on the ground floor.

Residents in Mountain View were under the care of the rehabilitation team (ten residents) or the community sector teams (seven residents). The rehabilitation team served a population of 256,000 in the former Dublin South West area and accepted referrals from four sector teams. All residents required continuing care because of long-term mental health needs and all were free to come and go as they wished.

Profile of residents

There were 17 residents at the time of inspection, ranging in age from 41 to 80 years. All residents were long-term service users of the mental health service and all were voluntary residents. Three were Wards of Court. All residents were mobile but many required assistance in showering and bathing.

The most recent person to be admitted to the residence was admitted two years ago and there had been no discharges since the house opened.

Two residents had particular needs in that they suffered from a hearing problem. This had led to some difficulties in communication as none of the staff members were trained in Sign Language. In addition, four residents had a learning disability.

Quality initiatives and improvements in 2014-2015

- The service carried out a number of audits and questionnaires including the Social Functioning Questionnaire (SFQ) and the Bartel Index of Activities of Daily Living, assessing individuals' level of social functioning and activities of daily living.
- A Pet Assisted therapist had commenced visiting the house weekly.
- An audit, using an audit tool called the Quality Indicator for Rehabilitative Care (QuIRC), was in the process of being carried out for all residents. This allowed the service to compare Mountain View with other community residences in the area on a number of different areas of operation.
- Staff had received training in Recovery in the past year.

Care standards

Individual care and treatment plan

The clinical files of seven residents were inspected. All residents had an individual care plan (ICP) which detailed goals, interventions and a responsible member of staff for carrying out the interventions. However, due to a lack of health and social care professionals on the rehabilitation team, these ICPs were not truly multidisciplinary. Reviews of the ICPs were generally every six months or annually, in a few cases. This was dependent on the needs of individual residents. Risk assessments were carried out and were reviewed regularly, as needs indicated.

An art teacher facilitated a painting session each week, and this was popular with residents. Many of the art works on display in the house had been painted by residents and included a series of paintings with a pronounced avian theme.

An activities therapist accompanied residents on outings from the house and had the use of a people carrier for further trips.

Physical Care

Residents attended a general practitioner (GP) in the Primary Care Centre, adjacent to the residence. Depending on their ailment, they would attend accompanied or not. The GP generally communicated with staff by fax if they wished to relay test results or any other relevant information. Residents had an annual physical check-up and blood tests were carried out for metabolic screening. Residents who were not under the care of the rehabilitation team attended for review at their sector outpatient clinics.

Therapeutic services and programmes provided to address the needs of the residents

Most of the residents attended some activities or therapies during the course of the week. Two locally run activities took place in the local community centre and were attended on a regular basis.

A further Clubhouse group met daily, Monday to Friday, for activities such as yoga, relaxation, computer work etc. and six residents attended daily.

Residents in one of the houses were more independent than others and participated in cooking meals in the evening meal and at week-ends.

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

The residence was well located in Ballyfermot and there was ready access to public transport. Residents visited coffee shops and shops in the local area. Several residents attended local community activity groups which were also attended by residents of the local area.

Facilities

The residence was a relatively new structure and was an attractive building and well maintained. Although it was quite a large building, it was subdivided internally into three: Houses 1, 2 and 3, each with its own sitting rooms and kitchen cum dining areas. The downstairs living areas of each of the three Houses were connected with each other. Inspectors noted that connecting doors between the Houses were held open by means of a fire extinguisher, in one instance, and a flower pot in another.

All bedrooms were single rooms with en suite facilities. The bedrooms were large, nicely designed and had adequate storage space. There were two bedrooms downstairs and these were suitable for residents who would find it difficult to climb the stairs.

The residence was surrounded by a garden area; the rear garden backed onto the Cherry Orchard Hospital campus.

Each House had a laundry room and some of the more independent residents did their own laundry. Staff assisted other residents.

When queried about the presence of security personnel on-site each night from 2000h to 2400h, staff reported that there had been a number of anti-social incidents nearby, some in the grounds of the residence. Staff also reported an incident where a break-in was detected in one of the ground floor rooms. Following these incidents, the service engaged a security firm. A review of the Incident Report book, however, did not identify the incident of the break-in. CCTV cameras were in use on the perimeter of the building and were monitored by the security personnel.

Meals

The main meal of the day was delivered daily, Monday to Friday, from the Ballyfermot Resource Centre. It arrived in containers and was then plated by the HCA staff. There was no choice of meal for dinner, which was the main meal. On the day of inspection, inspectors saw the dinner which did not provide a choice. There was a choice, however, on Fridays, for those who did not eat fish.

At week-ends, staff bought the necessary ingredients from local shops with a Health Service Executive (HSE) card and cooked the meals. In one of the Houses, the residents themselves cooked their evening meal. There was access to tea and coffee making facilities in each House.

Staffing levels

STAFF DISCIPLINE	DAY WTE	NIGHT WTE
CNM2	1	0
RPN	1	1
HCA	1	1

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

Team input

DISCIPLINE	NUMBER WTE	NUMBER OF SESSIONS
Consultant psychiatrist	1	Weekly
NCHD	1	Weekly
Occupational therapist	2	None Access as required
Social worker	0.5	None Access as required
Clinical psychologist	0	None Access as required
Art Teacher	1	One weekly

Non consultant hospital doctor (NCHD)

The staffing levels above relate to the rehabilitation team. Ten of the residents in the house were under the care of the rehabilitation team and seven were under the care of their sector team. The rehabilitation consultant and NCHD attended the residence once weekly or more often, if required.

Although there was no Speech and Language Therapist (SLT) on the rehabilitation team, there was access to this service from the Ballyfermot Sector team. Similarly, the rehabilitation team did not have a dietician, but there was access to a dietician in Tallaght Hospital. One of the occupational therapy posts was vacant due to extended leave of the post holder.

The sector teams had a psychologist and access was as required.

An activities therapist regularly accompanied residents on trips out of the residence. There was one WTE household staff member in the residence daily.

A security staff member was on duty in the residence daily, from 2000h to 2400h.

Medication

Medications were prescribed by both the psychiatrist and the GP. All prescriptions had to be transcribed onto a GMS prescription form which was then passed to the pharmacy. Medications were procured from a local pharmacy and were delivered monthly. All residents paid the drug prescription charges to the pharmacy.

Nursing staff administered the medications to residents. One resident was on a self-medicating programme, and was given a daily supply of medications for self-administration.

Long acting depot medications were administered in the residence.

Tenancy rights

Charges for residents ranged from €70 to €120 per week. Charges were individually determined, depending on both the income and allowances for each individual resident. There was no 'social fund' in operation.

Community meetings did not take place. Staff reported that residents would approach nurses with complaints, if they wished and staff endeavoured to sort these out. No copy of complaints was maintained. There was a notice in the hall about how to make complaints, but the information related to a Health Board area which was no longer in existence.

Following receipt of the factual corrections, a senior staff member reported that a plan had been instituted to facilitate weekly community meetings and a complaints log had been commenced.

Financial arrangements

Most residents had their own bank account and staff accompanied them to withdraw money, if this was required. Most paid the HSE charges by direct debit from this account. A certain amount was then withdrawn weekly by each resident for use during the week.

Nursing staff maintained a record of what monies a resident had and this was kept in a safe. When a resident wished to access their money, the signature of both the resident and a nurse was recorded. Staff reported that no HSE audit of resident finances had taken place since the residence opened in 2011.

Service user interviews

A number of residents engaged in conversation with inspectors during the course of the inspection and most expressed their satisfaction with the residence and staff. Due to a lack of clarity around meal choices, inspectors spoke with a number of residents who confirmed that there was no choice for dinner, except on a Friday. One resident was unhappy with the quality of the food. Another resident raised a number of issues with inspectors which were then drawn to the attention of staff, with the resident's consent.

The designated advocate for the area did not visit the residence.

Conclusion

Mountain View was a recently constructed building, purpose-built for the accommodation of residents in long-term care of the mental health services. It was an attractive building and was well situated in a residential area, close to public transport. The accommodation provided was excellent and each resident had their own well designed bedroom and bathroom facilities.

Most residents were under the care of the rehabilitation team which emphasised a recovery ethos to care and treatment. However, there were at least two residents who were acknowledged by the service to be inappropriately placed in this setting. The rehabilitation team was actively engaged with the appropriate service with a view to securing more appropriate accommodation for these residents. All residents had an individual care plan, which was excellent, but these care plans were limited in what therapies could be provided due to the lack of health and social care professionals on the rehabilitation team.

The lack of choice in the main meal of the day was highlighted by some residents and evidence of this was seen by inspectors on the day of inspection. Following receipt of factual corrections from the service, a senior member of staff reported that a meeting had been arranged with the meals provider to explore options of providing greater choice of dinner meal.

Recommendations and areas for development

1. *The rehabilitation team should be fully resourced with medical and nursing staff and health and social care professionals.*

2. *Residents should be offered a choice of meal, particularly at dinner time.*

3. *A record of complaints received should be maintained in the residence.*