Mental Health Services 2013

Inspection of 24-Hour Community Staffed Residences

EXECUTIVE CATCHMENT AREA/INTEGRATED SERVICE AREA	Limerick, Clare, North Tipperary
HSE AREA	West
MENTAL HEALTH SERVICE	Limerick Mental Health Service
RESIDENCE	O'Connell House
TOTAL NUMBER OF BEDS	28
TOTAL NUMBER OF RESIDENTS	23
NUMBER OF RESPITE BEDS (IF APPLICABLE)	0
TEAM RESPONSIBLE	Rehabilitation Team
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	25 April 2013

Summary

- O'Connell House residents were under the care of the Rehabilitation team. However, no residents were discharged to more independent accommodation in 2013 to the date of inspection.
- The standard of maintenance was poor and staff reported the residence had not been painted for several years.
- In spite of some bright areas, the residence was dirty and neglected looking in places. There was no onsite supervision for household staff.
- There were few activities for residents who did not attend the day centre.
- The service transport was not wheelchair accessible, so some residents could not avail of it.

Description

Service description

O'Connell House was situated in a suburban area outside Limerick City. It was opened in the early 1990s to accommodate residents from St. Joseph's Hospital in Limerick, which was in the process of closing. A single-storey, red brick building, it was built on a large site, around an internal square garden. Externally, paintwork looked worn. It had been established as a rehabilitation service, but staff reported that discharges were rare and there had been no discharges to independent or less supervised accommodation in the year prior to inspection. They felt that it was functioning as a continuing care unit. Some residents could be accommodated in alternative accommodation, but they had refused to move elsewhere. Staff were unaware if the residents had signed a tenancy agreement at the time of admission.

Profile of residents

Of the 23 residents, there were 12 male and 11 female. One male resident had been transferred to the acute admissions unit in Limerick. There were no Wards of Court. The residents ranged in age from the late 40s years to early 90's, with residents predominantly in the older age group. A number of residents had limited mobility so that they were unable to partake in activities. Many had been resident since the service opened.

Quality initiatives and improvements in 2012/2013

- A new risk assessment matrix had been introduced and training was in its use was being arranged on the day of inspection.

Care standards

Individual care and treatment plan

Residents were admitted from St. Joseph's Hospital or other residential services under the auspices of the Rehabilitation team. Medical Assessment Forms and CASIG (Client Assessment of Strengths, Interests, Goals) nursing assessments were in the clinical files. However, the former had not been completed in the case of three clinical files which were examined. Formal risk assessments were not completed by the team prior to admission to the service.

Multidisciplinary meetings were held monthly and staff reported that they were attended by all members of the team. Residents were reviewed on a rotational basis or as needed and referrals to the service were discussed there.

Individual Care Plans (ICPs) were completed. However, there were two versions of the ICP in use, one of which did not document goals. Neither identified the persons responsible for interventions. The range of interventions did not reflect the full needs of the resident, for example, although staff reported that residents attended the day centre next door, this was not documented. The ICPs were sometimes not signed and the section on whether the resident had received or refused a copy was not completed.

Each resident had their own GP who conducted six-monthly physical reviews. Those who could do so attended the surgeries for this and staff reported that a record was kept in the clinical files and the nursing diary.

A chiropodist attended on request and this service was paid for privately.

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

Staff reported that a range of board games, interactive ball games and card games as well as TV were available to the residents in the house.

Residents were referred to the day centre next door to the residence, which was attended by the occupational therapist. There they could avail of a range of therapeutic activities i.e. art, computers, woodwork, horticulture, literacy and numeracy and out and about activities. Residents had access to a kitchen in the day centre under supervision.

The range of activities in the residence had been reduced as a result e.g. the activities kitchen had been closed in the previous six months.

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

Staff had recently secured access to a minibus to facilitate outings for the residents. These outings took place about once or twice a month depending on staff availability. However, as the minibus was not wheelchair accessible, only ambulant residents could avail of it. One or two residents were facilitated in going into Limerick city by bus. Staff reported other residents were unable to do this.

Staff reported that some residents went to the local shops, cafes or bingo. For those residents who could not, a hairdresser, barber and beautician attended weekly and clothing retailers attended on request. A volunteer musician service had been discontinued in the previous few months as staff hoped to be able to recruit a music therapist.

Facilities

There were 12 single bedrooms and 5 three bedded rooms. All but one, which was very small, had a sink. All had privacy curtains, lockers and lockable wardrobes. Some had been comfortably adapted by the occupants. Others were bare and devoid of personal affects. In one instance, the resident's clothes were in disarray and falling out of the wardrobe because of insufficient storage space. The paint was peeling in some areas. Staff reported the house had not been painted in several years. The standard of decor was poor and it was institutional in appearance.

While the general sitting area and the dining rooms were bright and welcoming, some areas were dirty. The floor in the visitor's room was soiled, the table was marked and the wall needed to be washed. One toilet was dirty and the soap dispenser was congealed. A wall-mounted TV in one bedroom was covered in a thick layer of dust. Staff reported they were aware of the problem, but they were not responsible for cleaning standards in the house as line management for this service was based in St. Joseph's Hospital.

A second sitting area which had previously been used as an activities room was used as a second TV room. Chairs and a dining table were lined against the wall, adding to the institutional air.

A bedroom had been converted into a relaxation room and Snoezelen multisensory facilities had been installed. However, the room was too small to accommodate an extending relaxation chair and so two small upright chairs were in use.

The garden area was underdeveloped and the surrounding pathway was flooded on the day of inspection. Similarly, a path leading to the nearby day centre was flooded.

Two extractor hosepipes from the electric dryers leading into the garden area were exposed. They were clogged with dirt and dust from the dryers. One had no grille to protect from intrusion by vermin.

The air in one shower room was humid. Staff reported the extractor fan was broken and a request for maintenance had been made.

In the laundry room one of the two washing machines was broken on the day of inspection. Staff reported that had occurred that morning. Staff reported that household staff generally did the washing for the residents and all clothing was marked for identification purposes.

A social skills kitchen had been closed to residents for the previous six months as this function had been transferred to the nearby day centre.

A choice of menu was available to residents and the service had access to a dietician from Primary, Community and Continuing Care.

Staffing levels

STAFF DISCIPLINE	DAY WTE	NIGHT WTE
CNM 1	6 hours (shared with day centre temporarily)	0
CNM 2	1	0
RPN	2	3
Housekeeping	2	0
Cook	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	Monthly or as needed
NCHD	1	Monthly or as needed
Occupational therapist	1	Monthly or as needed
Social worker	1	Monthly or as needed
Clinical psychologist	1	Monthly or as needed

Medication

Psychiatric medications were reviewed at ICP reviews which took place on a rotational basis. Psychiatric medications were prescribed and reviewed by the psychiatrists. The GP prescribed medication for general health and rewrote the psychiatric prescriptions for medical card purposes. Nursing staff administered depot injections.

Tenancy rights

A flat rate charge of €80 was levied on all residents, which include €25 for rent and €55 euro for food and utilities.

Community meetings were held monthly. The complaints procedure was highlighted. However, no complaints log was available on the day of inspection. Staff reported that serious complaints were included in the incident reports which were sent to the Director of Nursing and included in the STARSWeb system. Less serious complaints were dealt with at the community meeting and staff reported to the Inspectorate subsequently that these were recorded there.

Financial arrangements

All residents had their own bank or post office accounts and staff reported residents were assumed to have capacity to manage their own affairs in the first instance. Those that could, collected the cash they needed each week and gave this to the nursing staff for payment against the charges and for the safekeeping of small amounts of money. For those that could not, an agency system was used, which allowed the CNM to collect the money for them. Money was lodged into a ledger although receipts were not issued at that point. Withdrawals were countersigned by the resident or for those not able to do this, two nursing signatures were used. If a resident was on leave a waiver of rent was arranged. Residents kept small amounts of cash in their own lockable wardrobes.

Some social activities were paid for individually by residents while others were provided by the HSE. The day centre activities were funded by the VEC. The use of a centralised social fund had been discontinued in recognition that not all residents participated in activities. Individual care plans did not specify social activities.

The cost of daily newspapers was included in the rental charge and the TV licence was paid for by HSE. Those residents who attended rehabilitation training workshops were entitled to a rehabilitation allowance from the HSE.

Service user interviews

A number of residents were greeted the course of the Inspection. All said they were happy in the service.

The records did not show that residents had access to their ICPs. There were no information leaflets on display in the residence.

Conclusion

Residents of O'Connell House were under the care of the rehabilitation team. However, most residents were long stay and staff reported that no residents had moved to independent accommodation, or less supervised accommodation in the year prior to Inspection.

The premises were in poor decorative order and dirty in places. It was institutional in appearance. The main sitting area and the dining area were bright and welcoming. There were few dedicated activities within the house and staff reported that residents were encouraged to attend the nearby day centre for this. A range of activities was available in the day centre, which was staffed by an occupational therapist from the community mental health team as well as the CNM1 whose post was shared with the residence. Some residents refused to attend the day centre and the range of services in the residence was limited.

The interior garden was flooded on the day of Inspection. Dirty hosepipes opened onto the garden area.

Individual Care Plans were used, but inconsistently. There was no evidence within the clinical files examined that formal risk assessments were conducted on residents prior to admission.

Recommendations and areas for development

1. *Consideration should be given to the completion of the form used for medical assessment at admission. If this is not to be done, a case summary should accompany the patient. A formal risk assessment should be completed by the referrer prior to admission.*

2. *Standards of cleanliness in the residence and difficulties in the line management of household staff should be addressed.*

3. *The interior and exterior of the residence should be painted and the overall decor should be refreshed.*

4. *While the day centre is very helpful to some residents, the needs of those who do not attend should be addressed by the provision of a range of activities of interest to them.*

5. *Consideration should be given to relocating the Snoezelen multisensory facilities to a larger room.*

6. *Individual care plans should be signed by the resident and if not this should be recorded. The version of the ICP in use in the residence should be clarified. The activities beneficial to each resident should be specified in the ICPs.*

7. *Consideration should be given to the provision of wheelchair accessible transport to facilitate the participation of the more disabled residents in social activities.*

8. *Flooding in the garden and on the pathway to the day centre should be addressed and the exposed hosepipes in the garden should be repaired.*

9. *Receipting or countersigning lodgements of residents' funds must be recorded in the ledger.*

10. *A log of complaints should be kept.*